

**Subject Access Request Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER**



Private

MMA Legal Limited
Stok
43 – 59 Princes Street
Stockport
SK1 1RY

Date: 8th May 2026
Your Ref: 100016
Our Ref: SAR / ACCESS / CF
Enquiries to: Caroline
Direct Line: 0141 201 3380
Email: Caroline.Forsyth@ggc.scot.nhs.uk

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: Deborah Sullivan D.O.B: 07/12/1972

Thank you for your recent request in which you seek a copy of your client's personal information.

Your request has been dealt with in line with our requirements under Article 15 of the General Data Protection Regulation and I now attach the following:

**GLASGOW ROYAL INFIRMARY RECORDS / STOBHILL ACH RECORDS
PRINCESS ROYAL MATERNITY RECORDS / DENTAL HOSPITAL RECORDS**

Please be aware that these health records have been reviewed by a clinician and any information identifying or provided by a third party has been removed.

We process personal information to enable us to provide healthcare services for patients; support and manage our employees; to carry out research and clinical trials; maintain our accounts and records and to carry out data matching under the national fraud initiative. We also use CCTV systems for crime prevention.

This personal information can be both clinical and non-clinical in nature and can include

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images
- Witness statements
- Incident reports
- Complaints files
- Emails

The source of our data includes Patients, General Practitioners, Healthcare, Social and Welfare organisations, Legal representatives and Police forces.

We sometimes need to share the personal information we process with the individual themselves and also with other organisations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation

Where these organisations are based outside Europe we take all appropriate safeguards to protect your information.

Health records are kept for a limited time and this is noted below for your information

- Adult general hospital records – six years after the date of last entry
- Maternity records – 25 years after the birth of the last child
- Children's and young people's records – until the child or young person's 25th birthday.
- Mental health records – 20 years after the date of the last contact

If you have any queries, please do not hesitate to contact us.

If you are unhappy with how your request has been dealt with please contact the NHSGGC Data Protection Officer. Their contact details are noted below:

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email: data.protection@ggc.scot.nhs.uk

Yours sincerely

Subject Access Request Team

ELECTRONIC PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC

☐

ACS

☐

BEATSON HOSPITAL

☐

CANNIESBURN HOSPITAL

☐

DENTAL HOSPITAL

☐

GARTNAVEL GENERAL HOSPITAL

☐

GLASGOW ROYAL INFIRMARY

☒

3 of 6

INVERCLYDE ROYAL HOSPITAL

☐

MATERNITY

☐

NEW VICTORIA ACH

☐

PRINCESS ROYAL MATERNITY

☐

QUEEN ELIZABETH UNIVERSITY HOSPITAL

☐

MATERNITY

☐

ROYAL ALEXANDRA HOSPITAL

☐

MATERNITY

☐

ROYAL HOSPITAL FOR CHILDREN

☐

STOBHILL HOSPITAL

☐

VALE OF LEVEN

☐

MATERNITY

☐

WEST CARE AMBULATORY HOSPITAL

☐

WESTERN INFIRMARY RECORDS

☐

Including:

BADGERNET

☐

CAREVUE

☐

MEDICAL ILLUSTRATION

☐

METAVISION

☐

PHYSIOTHERAPY

☐

RADIOLOGY

☐

WEST MARC

☐

LABS

☐



CHI: 0712726128

Glasgow Royal Infirmary

(15)

Total Att: 28

12 Mth Att: 6

Title: MS

SULLIVAN

Deborah

ecg✓

DOB: 07/12/1972

Age: 45y

Sex: Female

1/1 34 Pendeen Place

Next of kin: KELLY, Courtney

Relationship: Daughter

07487257039

Glasgow

G33 4UG

07713718392

GP: G MacAllister

0141 531 8050

Attendance Date: 15/02/2018

Arrival Time: 04:21

Registration Time: 04:21

Date of Incident: 15/02/2018

Major Incident Desc:

Reason for Attendance: overdose

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 15/02/2018 04:28

Nurse name: Nurse Nicole Pratt

Temp	36.6	C
HR	121	bpm
BP	109/75	mmHg
MAP	86.33	mmHg
RR	18	bpm
SpO2	90	%
Oxygen		%

BM	8.7(SAS)	mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	3
Motor	6
Verbal	4
Total	13

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: OD tonight approx. 84 pill (diazepam, temazepam and pregabalin). Hx depression hallucinations. Known to CPNS. NEWS 2

0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah

To be Completed by Clinician

Questionnaire	Yes	No
ma from previous presentations)		
entation		
baby or non-mobile toddler		

Printed: 15/02/2018 05:21:06

Patient Sample Report

Status: ACCEPTED

Analyzed: 15/02/2018 05:20:56

Sample Type: Arterial

Account Number:

Clinician:

Operator ID: LYNSEY BROWN0

f / Nurse on duty any factors identified

Time Seen

Patient

ID: 07-12726128
 Last Name: SULLIVAN
 First Name: DEBORAH
 Gender/Age: Female, 45 years
 Birth Date: 07/12/1972

Cartridge

Lot No.: 171227C
 S/N: 000000000400016905
 Exp. Date: 07/03/2018

Analyzer

Model: GEM® Premier 5000
 Area: GRI
 Name: CASU
 S/N: 16090423

Results

			Crit. Low	Reference Low	High	Crit. High
Measured (37.0°C)						
pH	↓ 7.35	nmol/L	--	36.0	44.0	--
pCO ₂	↓ 5.3	kPa	--	4.6	6.0	--
pO ₂	↓ 7.7	kPa	--	10.5	14.0	--
Na ⁺	137	mmol/L	--	133	146	--
K ⁺	4.5	mmol/L	--	3.5	5.3	--
Cl ⁻	↑ 109	mmol/L	--	95	108	--
Ca ²⁺	1.24	mmol/L	--	1.15	1.27	--
Glu	↑ 6.9	mmol/L	--	3.5	6.0	--
Lac	1.3	mmol/L	--	0.6	2.2	--

CO-Oximetry

lHb	144	g/L	--	117	174	--
O ₂ Hb	↓ 84.2	%	--	95.0	98.0	--
COHb	↑ 6.5	%	--	0.5	1.5	--
MetHb	↑ 5.3	%	--	0.5	1.5	--
HHb	↑ 8.5	%	--	0.0	5.0	--
so ₂	↓ 88.8	%	--	95.0	98.0	--

Derived

BE(B)	↑ 5.8	mmol/L	--	-2.0	3.0	--
HCO ₃ ⁻ (c)	↑ 30.6	mmol/L	--	21.0	28.0	--
Hct(c)	43	%	--	35	51	--

↑↓ Outside Reference Range

Other Information

Operator Entered:

Temp 37.0 °C

(Including Tetanus Prophylaxis)

Method of Administration	Time of Administration	Signature	Given By
--------------------------	------------------------	-----------	----------

2/15/2018

Incident Number: CR00424581

Patient Information

DEBORAH SULLIVAN

Age/Gender: 45 years 2 months 8 days Old Female

Address: 1/1 34 PENDEEN PLACE BARLANARK
GLASGOW, G33 4UG

DOB: 07/12/1972

CHI:

Ethnicity: --

Incident Date: 15/02/2018

Incident Number: CR00424581

Incident Type: EMG

Incident Location: 1/1 34 PENDEEN PLACE
BARLANARK GLASGOW,
G33 4UGScottish
Ambulance
Service
Dumfries & Galloway

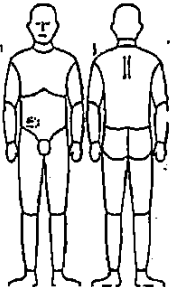
Presenting Complaint

OVERDOSE

Additional Comments

999 CALL TO 45YOF O/A POLICE IN ATTENDANCE. PT ALERT, SLUMPED TO SIDE ON SOFA O/E OBS AS BELOW. PT HAS MENTAL HEALTH ISSUES AFTER A RAPE 17 YEARS AGO. PT HAS DEPRESSION AND PSYCHOSIS. PT HALLUCINATES THAT ATTACKER IS IN HER HOME AND HEARS VOICES. PT TOOK 85 PILLS OF TEMAZAPAM, DIAZEPAM AND PREGABILIN. HAS 7/1 PAIN IN ABDOMEN

PATIENT ASSESSMENT

AVPU	Alert	<C>	No						
A	Clear								
B									
C	Pulse Rate 121	BP 133/93	Cap Refill <=2 Secs						
	Rhythm Reg	Arm Right	ECG Rhythm Sinus Tachy						
		Central/Peripheral Peripheral	ECG 3 Lead						
D	GCS 15	Eyes Spontaneously (4)	Voice Orientated (5)						
		Motor Obeys Commands (6)	PEARL Yes						
E									
 <table border="1"> <thead> <tr> <th>ID</th> <th>Body Part</th> <th>Pain Scale</th> </tr> </thead> <tbody> <tr> <td>P1</td> <td>Abdomen</td> <td></td> </tr> </tbody> </table>				ID	Body Part	Pain Scale	P1	Abdomen	
ID	Body Part	Pain Scale							
P1	Abdomen								
 0712726128 SULLIVAN Deborah 1/1 34 Pendeen Place Glasgow F 07/12/1972 G33 4UG									

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrowdID
04:05	120	28	128/89	96	<=2s	15	Alert		37.5	8.7	Sinus Tachy				E9888615
03:40	121	28	133/93	95	<=2 Secs	15	Alert		37.5	8.7	Sinus Tachy				E9888615

NEWS

Time	Clinical Risk	NEWS
04:05	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	5
03:40	MEDIUM Immediate Clinical Risk. Treat as per Clinical Practice Guidelines. This patient should be conveyed to hospital.	6

Drugs

HISTORY

AMPLE

Allergies	PENICILLIN
Medication	LIST PT
Past Medical History	Hypertension, PANCREATITIS, GALL BLADDER REMOVED, FIBROMYALGIA, DEPRESSION, HALLUCINATIONS, PSYCHOTIC EPISODES, SELF HARM, SUICIDE ATTEMPTS, RAPED 17 YEARS AGO

21/5/2016

Incident Number: CR03424581

Overdose	How Many:3	Suicide Attempts	How Many:3
Last Eaten	>4 Hours Ago		

Social History

Lives alone	Yes	Patient Occupation	Unemployed
-------------	-----	--------------------	------------

Patients General Appearance	UNKEEPT
-----------------------------	---------

Patient Mobility	Fully Mobile
------------------	--------------

Patient Communication	No Help Required
-----------------------	------------------

Patient Clinical Risk Factors	Smoker
-------------------------------	--------

Patient Environmental Risk Factors	None Identified
------------------------------------	-----------------



0712726128

SULLIVAN

Deborah

1/1 34 Pendeen Place

Glasgow

F

07/12/1972

G33 4UG

SOCRATES

Site	ABDOMEN	Onset	02:30
------	---------	-------	-------

Safeguarding

Safeguarding History	Self Harm
----------------------	-----------

Safeguarding Signs/Concerns	Psychological Harm
-----------------------------	--------------------

Safeguarding Assessment	Adult >= 16	Suicide Attempted	Patient	Safeguarding Category	High Of Risk
-------------------------	-------------	-------------------	---------	-----------------------	--------------

Other History	RAPED 17 YEARS AGO
---------------	--------------------

MEDICAL

Overdose

Mode Of Poisoning	Ingested
-------------------	----------

OD Poisoning Substance Type	DIAZEPAM, PREGABALIN, TEMAZEPAM
-----------------------------	---------------------------------

Poisoning Date	15/02/2016	Poisoning Time	02:00
----------------	------------	----------------	-------

Substance Amount	84
------------------	----

CLOSE RECORD

Treatment On Scene	Non Emergency
--------------------	---------------

Conveyance

Transport To Hospital	Normal driving	Pro Alert	No
-----------------------	----------------	-----------	----

INCIDENT LOG

Time Call Received	02:50	Allocated	03:23	Mobile	03:25
First Resource On Scene		Crew On Scene	03:35	Crew Left Scene	03:58
Crew At Hosp	04:15	Receiving Hospital	GLASGOW ROYAL INFIRMARY	Clear Time	

Crew ID

E9888615

E9888000

Crew Grade

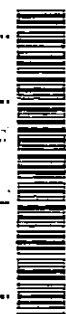
Ambulance Technician

Ambulance Technician

Driver

YES

NO



0712726128

SULLIVAN

Deborah

1/1 34 Pendeen Place

Glasgow

F

07/12/1972

G33 4UG

Emergency Department Nursing Documentation

Presenting Complaint - 00

Date - 10/2/17 Time - 0800

 0712726128 SULLIVAN Deborah 1/1 34 Pendeen Place Glasgow 07/12/1972 G33 4UG		Label
---	--	-------

Assessment Complete by: Name NURSE (Please Print)

L. D. A. N.

Patient Prep / Investigations

(Please tick/circle when completed)

Prepare patient for examination / Clothing bag labelled + Stored ☒

12 Lead ECG ☒

Weight: ☐

Blood Samples Obtained: YES ☒ NO ☐

IV Access: YES ☒ NO ☐

Blood Gas: VBG ☒ ABG ☐

Urinalysis

Leucocytes ☐	Nitrates ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G
MSSU / CSU ☐	Toxicology ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Communication

(Please Circle / Tick)

NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart) ☒

ID Band ☒

Peak Flow ☐

Xrays / CT Scan Performed: ☐

Relatives / NOK informed ☐

Child Protection Concern (considered in line with policy) Y/N

Adult Support and Protection Y/N

Screening Tools

(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more ☒

Mental Health Triage Assessment Y/N

GMAWS ☒

AMT 4 (> 65 YEARS) ☒

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) ☒
If at risk complete risk assessment

Frailty Screen (Would this person benefit from Comprehensive Geriatric Assessment (CGA)? (Age 75 or over/age 65+ from Nursing/Residential care or admitted from community hospital?)

1 Functional impairment in context of significant multiple conditions (new or pre-existing) Y/N

SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms) YES

IF NOT WHY? - (details) NA ☒

Time -

Date -

Signature -

2 Resident in a care home Y/N

3 Acute confusion (Think Delirium) is there a diagnosis of dementia or a history of chronic confusion Y/N

4 Immobility or Falls in the last 3/12 months Y/N

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? Y/N
If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA

2) Mobility Does the person require assistance? Y/N

3) Continence Y/N

4) Nutrition Y/N

Date

Location of Redness/Ulcers

Grade of Ulcer

5) Skin

Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?

Y/N

6) Judgment

In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS

Y/N

Patient Addressograph Label

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Name band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	Please note here if any other tasks required prior to transfer
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patient's medications)		☐	Always	
SAS Transport REQ / REF No		☐	☐	
Print Name				
Sign				

Nursing Notes

Date & Time		Print Name & Signature
16/2/18	Pt moved from maps to monitors pt taken off of own medication diazepam, Timazepam & pregabalin. Pt very drowsy responded to nasal pharyngeal airway, 2 tubes O2 insitu ECG & Bloods & VBC & access & Dr reviewing at the moment.	JBer
0700	Pt still responding to pain but very drowsy. Pt has to be on side. Sats: 100% on 28% O2. Pt to stay in A&E until more stable. News (7). Observations as noted GCS 14.	JBer
0810	Patient handed over by night shift GCS 13/15 awaiting bed in medical ward - JB	
0920	Patient incontinent of urine - personal care carried out. GCS 14/15 obs as charted	JBer
0935	Patient is GCS 15/15 when awake, falls back asleep - easily aroused now	JBer

Glasgow Royal Infirmary
Emergency Department



0712726128	
F SULLIVAN	07/12/11
972 Deborah	
1/1 34 Pendeen Place	
Glasgow	
JG	G33 41

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐	G+S ☐	X-match	units
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐
B culture ☐	C/MSSU ☐	Urinalysis ☐	BHCG ☐	Other		
CXR ☐	AXR ☐	Other imaging:				ECG ☐

Current location:

Sent by:

Clinical Notes

Date	Time	Name	Grade	Speciality
(45)		PC: verdon		
		verdon at 0200 - called 999 soon after		
		- 280mg diazepam		
		- 280mg temazepam		
		- 4.2g pregabalin		
		braxy on police / ambulance arrival		
		has become more drowsy since		
		PM Hx		
		PTSD & psychotic sx		
		Anxiety		
		Chronic paracetamol		
		RORD		
		Fibromyalgia		
		DHx: penicillin allergic		
		codeine	lactulose	diuretic
		simvastatin	cytisine	pregabalin
		serena	diazepam	aripiprazole
		temazepam	esareparal	ranipril
		paracetamol	venetriptan	
		naproxen	tolterodine	

Clinical Notes

Date Time Name Grade Speciality

O/E: *Dr*

Snoring - improves when - air - in side - or when prodded awake.

~~HA~~ *lost*
clear

H51+11+0. pulse regular. CRT < 2.

~~HA~~ *SNT*
BS+ve

~~HA~~ *lost*

~~HA~~ *lost*

Pupils large - equal + reactive

E₃ V₃ M₆ = 5 C5 12 Bm 8.7

HR 115 BP 129/87 RR 18 SpO₂ 95% on 28% ventur
Temp 36.6

napn ECG - sinus tachy. ⊕ intervals.

VB₄ - H⁺ 35.3 CO₂ 5.8 HCO₃ 30.6 lactate 1.3

Bloods unremarkable

Imp: mixed sedative overdose

Glasgow Royal Infirmary
Emergency Department

0712726128
F SULLIVAN 07/12/1
972 Deborah 1/1 34 Pendeen Place
Glasgow
JG G33 4

Clinical Notes

Date	Time	Name	Grade	Speciality
------	------	------	-------	------------

Plan: IV fluids

O₂

Admit medics

Nervous sys.

Can

**Glasgow Royal Infirmary
Emergency Department**

Patient Name
DoB
CHI Number
or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO ₂		
Hb			K			ALT			H ⁺		
Plat			Cl			AST			PaCO ₂		
Neut			Ur			GGT			PaO ₂		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

[illegible]

Review/Discussed with:	Handover:
	☐ Provisional Diagnosis
	☐ Liquids/Fluids
	☐ Analgesic/Medicines
	☐ NEWS
	☐ Investigations & Results
	☐ Talk to receiving team/ward

Nursing Admission & Assessment

1. Admission



Hospital: <u>GRT</u>	Ward: <u>SS</u>
Date of admission: <u>15/02/19</u>	Time: <u>1005</u>
Admitting Consultant:	Admitting Nurse: <u>Frances</u>
Expected date of discharge: <u>/ /</u>	

Na		0712726128
Ad	SULLIVAN	F
Do	Deborah	07/12/1972
	1/1 34 Pendeen Place	
Do	Glasgow	
CH		G33 4UG
NHS patient data label		

1. Patient Details	
Preferred name: <u>Debbie</u>	Next of Kin (NoK): <u>Colin May</u>
Age: <u>45</u>	Relationship: <u>Daughter</u>
Religion: <u>-</u>	NoK Address:
Telephone:	
GP:	NoK Telephone: <u>0748 725 7059</u>
GP address: Dr. G MacAllister McGill Practice Baillieston Health Centre 20 Muirside Road baillieston Glasgow G69 7AD	NoK Aware of admission: ☐ Yes ☒ No Consent for information to be given to relative/carer/friend: ☐ Yes ☐ No Nominated relative/carer/friend contact: <u>Donna Sullivan - Sister</u> <u>07743956178 (NoK)</u>
GP telephone:	Telephone - Day: Telephone - Evening:

Is the patient a carer? ☐ Yes ☒ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☒ No ☐ N/A

a. If 'Yes' please provide - Name: Relationship:
Contact telephone number:

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No
If 'Yes' obtain a copy and file with patient notes.

If 'No' to 'b' please inform medical staff. Name of doctor informed:

2. Presenting Complaint / Diagnosis

Have treatment / investigations: Overdose

Why does the patient think they are in hospital? Use patients own words:

3. Allergies (including food allergies)

No known allergies: ☐ Penicillin

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO ₂	Temp
	<u>PODRA</u>	<u>0</u>	<u>113</u>	<u>113/91</u>	<u>18</u>	<u>98.1</u>	<u>36.4</u>
Urinalysis: <u>Await</u>			BM	NEWS Score	Weight Patient reported for weight / Actual	Height Patients reported height / Actual	BMI
				<u>14</u>	<u>54.35</u>		

5. Current Medication

See med rec

6. Relevant Past Medical History

7. Risk Assessment

MUST Screening Tool

- Is the patient's BMI:
 - > 20Score 0
 - 18.5-20Score 1
 - <18.5Score 2
 Score 0
- Has the patient had unplanned weight loss in the past 3-6 months?
 - < 5%Score 0
 - 5-10%Score 1
 - >10%Score 2
 Score 0
- If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
 - Score = 2
 - Not applicable: Score = 0
 Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☒ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☒ No

Name 0712726128
 Address SULLIVAN
 : Deborah F
 07/12/1972
 DoB:
 CHI:

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs and

on patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

AMT

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☒ Yes ☐ No If 'Yes' complete the following section.

- Has the patient ever had a previous positive MRSA result? ☐ Yes ☒ No ☐ Not known
- Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☒ No ☐ Not known
- Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☒ No ☐ Not known

If 'Yes' to any of the above questions OR if the patient is admitted to a 'high impact speciality' e.g.

Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:

☐ Nasal ☐ Perineum ☐ Other - Specify: ☐ Patient refused

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☒ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☒ No If 'Yes' obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Are you a smoker ☐ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop?

If smoker how many cigarettes per day.....10.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☒ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

☐ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

☐ Never ☒ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): Frances Macaulay Signature: Frances Macaulay

Designation: RGN Date: 15/02/18

Nursing Admission & Assessment

2. Assessment

	
A 0712726128	F
SULLIVAN	07/12/1972
Deborah	
D 1/1 34 Pendeen Place	
C Glasgow	G33 4UG

Hospital: <u>ARG</u>	Ward: <u>SS</u>
Date of Assessment: <u>15/02/18</u>	Time: <u>1005</u>

1. Breathing and Circulation

Breathing:

- ☒ No symptoms or history of respiratory problems ☐ Productive / non-productive cough evident
☐ Dyspnoeic at rest ☐ Normally receives oxygen therapy
☐ Dyspnoeic on minimal exertion If 'Yes' provide details:
☐ Dyspnoeic on maximum exertion

Circulation:

- ☒ No symptoms
☐ known high blood pressure ☐ known angina ☐ current chest pain

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

FM

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required ☐ Not required ☐

If required, provide details and arrangement made:

Does the patient have:

- a. Speech difficulties? ☐ Yes ☐ No
 b. A learning disability e.g. Down's Syndrome?
 ☐ Yes ☐ No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team:

Liaison Learning Disability Team contacted:

☐ Yes ☐ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☐ No

If 'Yes' please specify:

3. Senses

Senses:

Eyesight

- ☒ Normal vision
☐ Glasses – ☐ Distance ☐ Reading
☐ Prosthesis – ☐ Left ☐ Right
☐ Contact lenses
☐ Registered blind

Hearing:

- ☒ Normal
☐ Hearing impaired
☐ Hearing aid – ☐ Left ☐ Right

4. Cognitive Status

Cognitive Status:

- ☒ Orientated
☐ Confused
☐ Distressed
☐ Aggressive / Abusive
☐ Known dementia
☐ Unconscious

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

FM

5. Hydration and Nutrition

MUST Score: 10 If score is 1 or more, complete a Nutrition Profile.

Nutrition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / /

5a.1. Food likes / dislikes:

No things.

5a.2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:

☐ Yes ☒ No

If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☒ No

If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?

☐ Yes ☒ No

If 'Yes' specify texture: A ☐ B ☐ C ☐ D ☐ E ☐

Thickened Fluids required? ☐ Yes ☐ No

If 'Yes' specify stage required: 1 ☐ 2 ☐ 3 ☐

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Diabetic Tr.

Initial

FM

6. Elimination

Continent:

- ☒ Bladder
☒ Bowel

Incontinent:

- ☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:

☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No

If 'Yes' is it urethral ☐ suprapubic ☐

If 'Yes' - Size: fg Make:

Date catheter last changed: / /

Continence assessment commenced:

☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☒ Bowels regular

☐ Constipated

☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No

If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

FM

Name	0712726128	
Address	SULLIVAN	
	Deborah	F
DoB:	07/12/1972	
CHI:		

7. Personal Hygiene, Oral Health and Skin Assessment



0712726128

SULLIVAN

Deborah
1/1 34 Pendeen Place
Glasgow

07/12/1971

G33 4UG

bel

Personal hygiene:

- ☒ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

- Self-caring and independent ☒ Yes ☐ No
Does the patient have a sore mouth ☐ Yes ☒ No

Does the patient have a non healing mouth ulcer ☐ Yes ☒ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:

Does the patient wear a denture plate?

- ☐ Yes ☒ No

If yes complete the following:

- ☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

- ☒ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☒ No ☐ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet - Grade:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

FM

8. Mobility

Patient fully mobile / independent? ☒ Yes ☐ No If 'No' complete Moving and Handling Assessment.

- ☐ Limited mobility
☐ Mobile with aid - Specify:
☐ Prosthesis - Specify:

Moving and Handling Plan commenced:

- ☐ Yes ☒ No

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

FM

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☒ No

If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☒ No

Bed rails required:

- ☐ Required ☐ Not required

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

FM

0. Sleep and Rest

Sleep habits:

- ☐ Less than 8 hours
☐ Morning nap
☐ Afternoon nap

Sleep difficulties:

- ☐ None
☒ Disturbed
☐ Early waking
 e.g. nocturia, insomnia

Medication required:

- ☒ Yes
☐ No

Angiprazole

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Hears voices

Initial

JM

Nan

Add



0712726128

SULLIVAN

F

Debora

07/12/1972

DoB 1/1 34 Pendeen Place

Glasgow

CHI

G33 4UG

1. Social Circumstances

- ☐ Employed ☐ Unemployed ☐ Retired
☐ Health problems at work
☒ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

- ☐ Social Services

Unpaid carer ☐ Yes ☒ No

If Yes are they Partner / Friend / Son / Daughter

What kind of care do they provide?:

- ☐ Private Carers
☐ None

If support services in place, please provide details:

Does the patient have any money worries? ☐ Yes ☐ No

If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?

☐ Yes ☐ No

If Yes please identify date patient referred:/...../.....

Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering

☐ Yes ☐ No

If Yes please identify date patient referred:/...../.....

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

JM

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

- ☐ Yes ☐ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

- ☐ Yes ☐ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

- ☐ Yes ☐ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

- ☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

14. **Anticipatory Care**
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☒ Not appropriate ☐

Appropriate ☐ Not appropriate ☒

NAME: _____
 0712726128
 SULLIVAN
 Deborah
 07/12/1972
 2/

Prognosis? ☐ Yes ☐ No

Home: ☐ — Hospital ☐ — Hospice ☐

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

Clinical Notes

[illegible]

Affix patient data.label

Clinical Notes (continued)

[illegible]

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)



0712726128
SULLIVAN
Deborah
1/1 34 Pendeen Place
Glasgow
07/12/1972
G33 4UG

Date & Time Consultant Ward

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on
Bleeders list ☐

Ward Review

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]



- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

0712726128	F
SULLIVAN	
Deborah	07/12/1972
1/1 34 Pendeen Place	
Glasgow	
G33 4UG	

Operative patients	Non-operative patients
Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?	
Yes ☐	No ☐

Does the patient have any risk factors for thrombosis? (tick $\checkmark$ all that apply)	
Age >60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI >30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐	No risk factors identified ☐
---	---

Indicators of high risk bleeding (tick $\checkmark$ all that apply)	
Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia
Acquired bleeding disorders (e.g. liver failure) ☐	• Expected within the next 12 hours
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	• Within the previous 4 hours ☐
Acute stroke (within 14 days) ☐	Other procedure with high bleeding risk - discuss with senior if unsure ☐
Persistent uncontrolled hypertension (BP $> 230/120$ mmHg) ☐	Acute bacterial endocarditis ☐
Thrombocytopenia ($<75 \times 10^9/l$) ☐	Surgery expected within the next 12 hours ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Trauma with high bleeding risk e.g. Head Injury ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	eGFR <30 ml/minute/1.73m ² : Dose reduction required ☐
	Heparin induced Thrombocytopenia ☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐	Contraindications to pharmacological prophylaxis identified ☐
---	--

Operative patients - Enoxaparin 40mg + AES ☐
 *prior to application of AES, please check contraindications to AES
Non-operative patients - Enoxaparin 40mg ☐
 Prescribe Enoxaparin at 6pm
 [on day of surgery, at the later of either 4h post-op or 6pm]
 Reduce Enoxaparin to 20mg if <50 Kg or eGFR <30 ml/minute/1.73m² ☐
 If weight > 120 kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
 Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐	
Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result - please tick $\checkmark$ all that apply			
VTE risk factors: YES ☐ NO ☐	Indicators of high risk bleeding: YES ☐ NO ☐	Prescribed: LMWH ☐ AES ☐ NONE ☐	
Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐	Information leaflet provided YES ☐ NO ☐		
Print Assessor's Name: _____	Signature: _____	Date: _____	

Medicine Reconciliation Form

Source of information:

ECS ☒

Patient ☒

Relative/
carer ☐

GP ☐

surg ☐

GP computer
printout/letter ☐

Patient's
own drugs ☐

Other
(specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				Reason for alteration
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	
SIMVASTATIN	20mg	OD	O				☒	
QUININE SULFATE	200mg	OD	O				☒	
SENNA	15mg	OD	O			☒	☒	DOESN'T TAKE
TEMAZEPAM	10mg	OD	O		☒			OD + DROWSY
PARACETAMOL	1g	QDS	O				☒	
NAPROXEN	500mg	BD	O				☒	
LACTULOSE	15ml	BD	O				☒	3.1-3.7g/5ml Solution
CYCLIZINE	50mg	PRN	O				☒	max TDS
DIAZEPAM	5mg	OD	O		☒			
ESOMEPRAZOLE	40mg	BD	O				☒	
RIZATRIPTAN BENZOATE	10mg	OD	O	☒			☒	TAKES PRN
DULOXETINE	60mg	BD	O		☒			DROWSY
PREGABALIN	300mg	BD	O		☒			OD + DROWSY
ARIPIPRAZOLE	10mg	OD	O				☒	} takes 25mg in am
ARIPIPRAZOLE	15mg	OD	O				☒	
LAXIDOL	1 SACHET						☒	
RAMIPRIL	2.5mg	OD	O	clarify				? STILL ON - LAST DISPENSED JANUARY 2018 - STILL TAKES
ACUTE : CODEINE PHOSPHATE	60mg	PRN	4-6					9 DROWSY
Allergies/adverse events								
PENICILLIN ☒								

List obtained by S. MULLEN Designation F42

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☒ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist A. HARRIS Date and Time 15/2/18 0945

Comments

Consultant Review

- Young man in genitourinary acute unit
Deliberate self poisoning - diazepam pre-gabalin
for psychiatric review

- Watch for + drinkers
Transfer GIM



0712726128
SULLIVAN
Deborah
1/1 34 Pendean Place
Glasgow

F
07/12/1972

G33 4UG

Check List

VTE ☐
Med - Rec ☐
Kardex ☐
CXR ☐
ECG ☐
Oxygen ☐

EDD

PRINT NAME

STO

DESIGNATION

Consultant

SIGNATURE

[Signature]

DATE & TIME

15/2/18

Clinical Notes

15-2-18 Nursing day

13:00 - Pt independent with wash this am

- meds given as prescribed
- obs stable as charted
- reviewed by medical team

* For ψ rlv

* For downstream

- settled at present - ~~on med~~

15/2/18 FY2 Mullen

15:00 (Written in retrospect)

Psychiatry contacted (were previously unaware of pt.)

- they will kindly c/v - may be tomorrow morning

Still drowsy - concable to voice & orientated to surroundings

- able to tell me tablets she is on

- AMT please dob age year

- telling herself to 'shut up' when got year wrong

→ gave correct answer eventually

- voicing that she had a 'voice inside her head' last night telling her to 'kill herself'

- she recognised it as the voice of her attacker

P. monitor closely

4° neuro obs

await ψ c/v, regular antipsychotics pr

will d/w car on evening round

15/2/18 FY2 Mullen

Alerted by ward staff pt distressed - hearing voices

- locked herself in bathroom

- may or may not have taken some tablets she had

in her bag (pregabalin, rizatriptan, paracetamol)

Clinical Notes

Obs: NEWS 3 SpO2 96% 4c RR 16 Temp 37.0°C

HR 105 BP 141/96

o/w pharmacy - on balance feels it would be safe to
(Andrew) give usual dose aripiprazole as missed
this am

o/w psych - still cannot see before tomorrow
- agree give aripiprazole
- diazepam is option but understand why as
has been drowsy
- suggest having someone sit w/ her

o aripiprazole now
o/w care as we
? 1:1 available



0712726128
SULLIVAN
Deborah
1/1 34 Pendean Place
Glasgow

07/12/1972

G33 4UG

[Signature]
F42

F42 Kazmi (H@N) 15/2 22:15

ATSP - threatening to leave

patient states she feels very agitated w/ voices in her
head. still orientated to place + person.

very tearful. states she has been asking for medication
but no one is listening. states she wishes to die.

I have apologized for delay in seeing her.

Note above entry stating she is ~~not~~ suitable for diazepam

o 5 mg diazepam if remaining unsettled

[Signature]

Nursing notes @0435 16/2/18

Patient has been settled for short periods
after 2300.

Medication given as per kardex.

Observations / obs stable as charted.

Patient has been independent to the
toilet to pass urine.

No concerns raised at this time.

A. Scott (Staff nurse)

Clinical Notes

15.2.18 hansen P

Seen today. Inpatient available of
own prescribed medication.
Fertile & great throughout IV.
Well known to d services and
has good insight. Continues to
express ongoing social isolation.
We will discuss situation with
her own team & return the
afternoon.

M Cassidy
CIN

16/2/18

WIK

Charlie
Gutty/dirty
Fertile

News O New.

Above noted by C/N for
news later today.

16/2/18 hansen P

Unable to speak to her
consistently & in view of preparation
we have arranged an inpatient
bed in Swan Road McKinnon house.
Please transfer with nurse escort.
Ding or advice of admission.

M Cassidy
CIN

200

0712726128
SULLIVAN
Deborah
1/1 34 Pendeen Place
Glasgow
07/12/1972
G33 4UG

Date & Time		Signature, Print Name & Designation
16/12/18	Nursing	
1455	Has been fairly settled throughout the day. Obs as charted. NEWS O. Oz discontinued. Meds as px. Seen by psych, pt to be transferred to Strawn ward at Sedhill today. Need to contact the word to clarify transport + escort. No answer as yet. Tearful at present, states she is all "going" & would like something to calm her down. Have informed pt I will speak to the doctors who are busy just now. Appears ok with this. NOK has been changed to Donna Sullivan (sister).	N- Finnigan N. Finnigan SN N. Finnigan SN
1630	Nursing Transferred to Strawn ward at McLennan House at Sedhill. Hospital taxi transport with staff escort. Taxi ref no. 83997. Ventilation removed. Appropriate notes transferred over. No concerns voiced.	N. Finnigan SN



CHI: 0712726128

Glasgow Royal Infirmary

Total Att: 27

12 Mth Att: 6

Title: MS

SULLIVAN

Deborah

DOB: 07/12/1972

Age: 45y

Sex: Female

1/1 34 Pendeen Place

Next of kin: SULLIVAN, KATHLEEN

Relationship: Parent

0141 771 3743

Glasgow

G33 4UG

07713718392

GP: G MacAllister

0141 531 8050

Attendance Date: 22/01/2018

Arrival Time: 03:16

Registration Time: 03:16

Date of Incident: 22/01/2018

Major Incident Desc:

Reason for Attendance: SFT-?pancreatitis

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 4

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 22/01/2018 03:19

Nurse name: Nurse Rebecca Smith3

Temp	36.8	C
HR	97	bpm
BP	152/88	mmHg
MAP	109.33	mmHg
RR	20	bpm
SpO2	94	%
Oxygen		%

BM	5.2	mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS:	
Eyes	
Motor	
Verbal	
Total	

Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "SFT" acute on chronic pancreatitis " hypoglycaemic with sas now resolved after glucojuice NEWS 2

0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah

[illegible]

Immediate Discharge Letter

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G3 7ER

Dr. G MacAllister
McGill Practice
Baillieston Health Centre
20 Muirside Road Baillieston
Glasgow
G69 7AD

Main Switchboard: 0141 211 4000

Date of Completion: 24/01/2018

Dear Dr G MacAllister,

Name	CHI	DoB	Address
Deborah Sullivan	0712726128	07/12/1972	1/1 34 Pendeen Place Glasgow G33 4UG

Admitted	Type	Discharged	Destination
22/01/2018 08:17	In Patient	24/01/2018	

Speciality	Consultant	Ward	Telephone
General Surgery	Mr William Kyle Mitchell	GRI Ward 66 General Surgery	0141 211 1930

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Diagnosis:
1) Abdominal pain unknown cause.

Background:

- 1) Chronic pancreatitis
- 2) Previous fundoplication and anterior wrap
- 3) Cholecystectomy
- 4) Appendicectomy
- 5) CGD in 2015 showing oesophageal spasm and gastric dysmotility
- 6) Fibromyalgia.
- 7) PTSD
- 8) Hypertension

Dear Doctor,

This 45 year old woman with a background of chronic pancreatitis and previous cholecystectomy, appendicectomy and fundoplication was

admitted to GRI on 22/1/18 with 2 days severe epigastric pain radiating to the back with nausea and loose bowels. She had had a recent flare up of her fibromyalgia. On admission she had epigastric tenderness. Obs were normal and bloods showed a raised WCC but were otherwise unremarkable, with a normal amylase.

CT showed nil acute and no cause for her pain. WCC improved to normal. Her pain is ongoing but improving, and she is now able to eat and drink. She is fit for discharge with no routine follow up required and no changes made to her medication.

Many thanks for your continuing care,
Bethan Williams FY1 ward 66 GRI

Treatments: None recorded.

Follow-up arranged: None

Planned Outpatient Investigations: None

Final Discharge letter to follow: yes

Medication Info:

Allergies:

Height: 178 cm

Weight: 101 kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
----------	-------	------	-----	-----------	----------	------------------

Discontinued Medication:

Drug Name	Dose	UOM	Reason
-----------	------	-----	--------

Yours sincerely,
Dr Bethan Williams2
Doctor

Prescription Review

Medications Reviewed by Pharmacist: ,

Dispensed Medications Checked by Pharmacy: ,

Nurse discharging patient: Bethan Williams2, Doctor

Date & Time 22/01/17 05:10 Consultant MITCHELL Ward 67

Ward Review

Check List

Bloods ☐

BHCG: +ve ☐ -ve ☐ N/A ☐

Urinalysis

ECG ☐

CxR ☐

AxR ☐

VTE prophylaxis ☐

Med Rec ☐

Kardex ☐

Mr C GASKEN surgical clerk-in

Δ 45 y/o F epigastric pain

GP referral

2/7 severe epigastric pain,
radiating to back.

associated nausea. vomiting.

no urinary symptoms.

Felt shivery this am.

bowels - looser than normal, no bleeding

no recent alcohol.

takes diclofenac regularly.

patient states recent flare of fibromyalgia

Background

chronic pancreatitis

fibromyalgia.

fundoplication, anterior wrap

cholecystectomy

appendicectomy

OGD 2015 → oesophageal strain/gastric dysmotility

tonsillectomy

PTSD

hypertension, migraines

Drugs

amipiracetate 25mg OD

cyclizine 50mg PRN

diazepam 5mg nocte

dibroxine 60mg BD

esomeprazole 40mg BD

lactulose PRN

naproxen 500mg BD with food

paracetamol 1000mg BD

pregabalin 300mg BD

quinine 200mg nocte

ramipril 2.5mg OD

trazodone 10mg PRN

gabapentin 200mg nocte

gabapentin 100mg nocte

Bloods

CRP 2

amylase (haem)
eGFR > 60

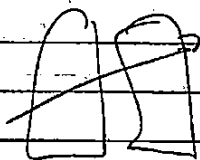
Flx
diabetes.

Stx
no alcohol.
smokes 12/day.
lives alone.

+rash with penicillin

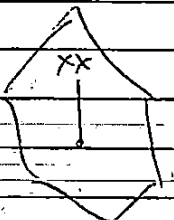
Ward Review

0/6



chest
- new

HS 1 KIT + O



tender epigastrium

BS +ve

? gastritis

? acute or chronic pancreatitis?

NEWS 0
apycemia

Plan

erect CXR, AXR

analgesia

repeat haemolysed bloods inc. amylase

IV fluids

PPI

22/01/18

review ST8 Wadhawan

07:00

He noted - severe epigastric pain
previous pancreatitis.



tender epigastrium

plan

IV fluids

Analgesia

[Signature]
CERTIFIED

PRINT NAME

DESIGNATION

SIGNATURE

22/01/18 TIME 30

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]



- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page

Pt Addressograph

Operative patients	Non-operative patients
Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?	
Yes ☐	No ☐
Does the patient have any risk factors for thrombosis? (tick $\checkmark$ all that apply)	
Age >60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI >30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐
Yes, 1 or more risk factors identified ☐	No risk factors identified ☐
Indicators of high risk bleeding (tick $\checkmark$ all that apply)	
Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia
Acquired bleeding disorders (e.g. liver failure) ☐	• Expected within the next 12 hours
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	• Within the previous 4 hours ☐
Acute stroke (within 14 days) ☐	Other procedure with high bleeding risk – discuss with senior if unsure ☐
Persistent uncontrolled hypertension (BP $> 230/120$ mmHg) ☐	Acute bacterial endocarditis ☐
Thrombocytopenia ($<75 \times 10^9/l$) ☐	Surgery expected within the next 12 hours ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Trauma with high bleeding risk e.g. Head Injury ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	eGFR <30 ml/minute/1.73m ² : Dose reduction required ☐
	Heparin induced Thrombocytopenia ☐
No contraindications to pharmacological prophylaxis identified ☐	Contraindications to pharmacological prophylaxis identified ☐
Operative patients – Enoxaparin 40mg + AES ☐ *prior to application of AES, please check contraindications to AES Non-operative patients – Enoxaparin 40mg ☐ Prescribe Enoxaparin at 6pm [on day of surgery, at the later of either 4h post-op or 6pm] Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐ If weight > 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline). Discontinue at discharge or when returned to pre-morbid mobility Contraindications to anti-embolism stockings (AES) Y ☐ N ☐ Peripheral neuropathy ☐ Peripheral arterial disease ☐ Cellulitis or Gross oedema ☐ Leg deformity or Fragile skin ☐ Leg / foot ulcers ☐ Allergy ☐ Unusual leg size/shape ☐	
Risk assessment result – please tick $\checkmark$ all that apply VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐ Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐ Print Assessor's Name: _____ Signature: _____ Date: _____	

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

Source of information:

ECS ☒Patient ☐

Relative/ ☐
carer

GP ☐
surg

GP computer ☐
printout/letter

Patient's ☐ own drugs

Other (specify) _____

Patient Name

DoB

Unit Number

or affix label

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Clinical Notes

Patient Name

DoB

Unit Number

or affix label

22/01 WR Mr Mitchell

05:20 Pt in pain - upper abdo, radiating through to back.



Tender

Imp: Pancreatitis

Plan: CT AP

Stop IUF

Measure Urine output

Elly Kennedy FY1

22/1/18 WR Mr Mitchell

09:00 News - 1

Pain ongoing, eating small amounts

Plan: 1) Await USS CTAP

W. Shillington FY1

23/1/18 WR Mr Mitchell

WCC 16.0 Anger 100, BSL 4 News - 1

Pt with pain in back & upper abdo
BMHs - gallbladder dysfunction, appendicitis

Order CTAP

4

A. Smith

9 Smith FY1

23/1/18 PHARMACY

Suggest ECG to check QTc - Rx 3 drugs that can prolong QTc (pre-admission med). Avoid starting future meds that could ↑ QTc eg ondansetron, metoprolol.

S. Dwyer

#15202

Clinical Notes

Patient Name
DoB
Unit Number
or affix label

en Place

G33 4UG

Last Emergency Care Summary received 11 January 2018

Description	Date Recorded	Comments						
Adverse reaction to <u>penicillins</u> rash	16-Feb-2009							
Auto Medication (including those greater than 30 days) Medication Reconciliation Report								
Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date		
In Practice	Codine Phosphate	60 mg Tablets	N/A	ONE TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN REQUIRED (MAXIMUM OF 4 IN 24 HOURS)	23-Nov-2017	09-Jan-2018		
Repeat Medication Medication Reconciliation Report								
Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
In Practice	Paracetamol	500 mg Capsules	N/A	2 Caps qds	18-Nov-2010	11-Jan-2018		
In Practice	Duloxetine	60 mg Gastro-resistant Capsules	N/A	1 Cap Twice daily	24-Nov-2015	11-Jan-2018		
In Practice	Pregabalin	300 mg Capsules	N/A	ONE CAPSULE TWICE DAILY (START THIS DOSE IN 7 DAYS)	28-Oct-2016	11-Jan-2018		
In Practice	Ramipril	2.5 mg Capsules	N/A	ONE TO BE TAKEN EACH DAY	02-Mar-2017	11-Jan-2018		
In Practice	Aripiprazole	10 mg Tablets	N/A	1 Tab Daily	27-Oct-2017	11-Jan-2018		
In Practice	Aripiprazole	15 mg Tablets	N/A	1 Tab Daily	27-Oct-2017	11-Jan-2018		
In Practice	Naproxen	500 mg Tablets	N/A	ONE TO BE TAKEN TWICE A DAY	27-Oct-2017	11-Jan-2018		
In Practice	Temazepam	10 mg Tablets	N/A	1 Tab Daily	27-Oct-2017	11-Jan-2018		
In Practice	Quinine Sulfate	200 mg Tablets	N/A	ONE TO BE TAKEN AT NIGHT	27-Oct-2017	11-Jan-2018		
In Practice	Rizatriptan Benzoate	10 mg Tablets	N/A	1 Tab Daily	27-Oct-2017	09-Jan-2018		
In Practice	Laxido Orange	Oral Powder Sachets Sugar Free	N/A	1 SACHET AS DIRECTED	23-Nov-2017	14-Dec-2017		
In Practice	Simvastatin	20 mg Tablets	N/A	ONE TO BE TAKEN AT NIGHT	27-Oct-2017	14-Dec-2017		
In Practice	Olanzapam	5 mg Tablets	N/A	1 Tab Daily	22-Dec-2011	14-Dec-2017		
In Practice	Esomeprazole	40 mg Gastro-resistant Tablets	N/A	1 Tab Twice daily	29-Dec-2011	14-Dec-2017		
In Practice	Citalopram	50 mg Tablets	N/A	1 Tab PRN MAX TDS	19-Jan-2015	14-Dec-2017		
In Practice	Tolterodine Tartrate	2 mg Tablets	N/A	ONE TO BE TAKEN TWICE A DAY	24-Jun-2015	14-Dec-2017		
In Practice	Lactulose	3.1-3.7 g/5 ml Solution	N/A	THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY	29-Mar-2011	14-Dec-2017		
In Practice	Senna	7.5 mg Tablets	N/A	TAKE TWO TABLETS AT NIGHT	16-Aug-2012	14-Dec-2017		

Confirmed to repeat s/p (Nov'17)

+

J. Syson Pharmacist 23/1/18

1/22/2018

Incident Number: CR004367846

Patient Information		Incident Date: 22/01/2018	 Scottish Ambulance Service
Deborah SULLIVAN		Incident Number: CR004367846	
Age/Gender: 45y Old Female		Incident Type: URG	
Address: 1/1 34 PENDEEN PLACE BARLANARK GLASGOW, G33 4UG		Incident Location: 1/1 34 PENDEEN PLACE BARLANARK GLASGOW, G33 4UG	
DOB: 07/12/1972			
CHI: 0712726128			
Ethnicity:			

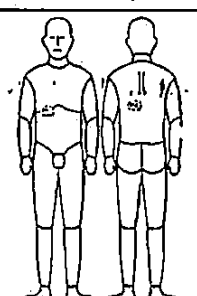
Presenting Complaint

PANCREATITIS

Additional Comments

GP URGENT CALL FOR 45 YOF CHRONIC PANCREATITIS. O/A PT EXPLAINED SHE HAS A HISTORY OF PANCREATITIS AND THIS HAS FLARED UP SINCE FRIDAY. GP ATTENDED ON SAT AND GAVE PAIN RELIEF. PAIN WORSENERD TONIGHT AGAIN AND TRAMILDOL GIVEN BY GP. ALL ROUTINE OBS TAKEN. ENTONOX GIVEN ONROUTE TO GRI MONITOR PT ONROUTE

PATIENT ASSESSMENT

AVPU	Alert	<C>	No									
A	Clear											
B												
C	Pulse Rate 105 Rhythm Reg	BP 134/93 Arm Left	Cap Refill ≤2 Secs Central/Peripheral Central ECG Rhythm Sinus Tachy ECG 3 Lead									
D	GCS 15 Eyes Spontaneously (4)	Voice Orientated (5)	Motor Obeys Commands (6) PEARL Yes									
E	 <table border="1"> <thead> <tr> <th>ID</th> <th>Body Part</th> <th>Pain Scale</th> </tr> </thead> <tbody> <tr> <td>P1</td> <td>Abdomen</td> <td>9</td> </tr> <tr> <td>P2</td> <td>Back Body</td> <td>9</td> </tr> </tbody> </table>			ID	Body Part	Pain Scale	P1	Abdomen	9	P2	Back Body	9
ID	Body Part	Pain Scale										
P1	Abdomen	9										
P2	Back Body	9										

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
02:50	98	16	136/95	98	≤2s										E1007106
02:38	105	18	134/93	97	≤2 Secs	15	Alert		37.1		Sinus Tachy				E1007106

NEWS

Time	Clinical Risk	NEWS
02:50	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1
02:38	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	1

Drugs

Time	Drug	Dosage	Units	Route	Drug Expiry Date	Pain Before	Pain After	CrewID
02:40	Entonox		PRN	INH				E0006149
02:50	Glucose 40% Oral Gel	25	g	OR	11/2018			E0006149

HISTORY**AMPLE**

Allergies: PENICILLIN

Printed: 22/01/2018 04:02:27

Patient Sample Report

Status: **ACCEPTED**

Analyzed: 22/01/2018 04:00:13

Sample Type: **Venous**

Account Number:

Clinician:

Operator ID: **MIKE LINZEE-GORDON0**

Patient

ID: 0712726128
Last Name: **SULLIVAN**
First Name: **DEBORAH**
Gender/Age: Female, 45 years
Birth: 07/12/1972

Cartridge

Lot No.: 171118B
S/N: 000000000400014641
Exp. Date: 05/02/2018

Analyzer

Model: **GEM® Premier 5000**
Area: **GRI**
Name: **CASU**
S/N: 16090423

Results

			Crit. Low	Reference Low	High	Crit. High
Measured (37.0°C)						
CH	42.3	nmol/L	--	--	--	--
pCO ₂	6.0	kPa	--	--	--	--
pO ₂	6.7	kPa	--	--	--	--
Na ⁺	138	mmol/L	--	133	146	--
K ⁺	3.9	mmol/L	--	3.5	5.3	--
Cl ⁻	107	mmol/L	--	95	108	--
Ca ⁺⁺	1.26	mmol/L	--	1.15	1.27	--
Glu	↑ 6.6	mmol/L	--	3.5	6.0	--
Lac	1.0	mmol/L	--	0.6	2.2	--

CO-Oximetry

lHb	134	g/L	--	117	174	--
O ₂ Hb	80.2	%	--	--	--	--
COHb	5.1	%	--	--	--	--
MetHb	0.7	%	--	--	--	--
HHb	14.0	%	--	--	--	--
sO ₂	85.1	%	--	--	--	--

Derived

BE(B)	0.3	mmol/L	--	--	--	--
HCO ₃ (c)	26.0	mmol/L	--	--	--	--
Hct(c)	40	%	--	--	--	--

↑↓ Outside Reference Range

Other Information

Operator Entered

Temp 37.0 °C

02/22/18

Incident Number: CR004367846

Medication SEE REPEAT PRESCRIPTION

Past Medical History PANCREATITIS, FIBROMYALGIA

Events Prior PANCREATITIS

CLOSE RECORD

Treatment On Scene Non Emergency

Conveyance

Transport To Hospital Normal driving Pre Alert No

INCIDENT LOG

Time Call Received 00:56 Allocated 01:27 Mobile 01:29

First Resource On Scene Crew On Scene 02:34 Crew Left Scene 02:46

Crew At Hosp 03:08 Receiving Hospital GLASGOW ROYAL INFIRMARY Clear Time

Crew ID

Crew Grade

Driver

E1007106

Paramedic

YES

E0006149

Ambulance Technician

NO

FAO Surgeons 22/1/2018 @ 00:40 Home visit
Greater Glasgow & Clyde Out of Hours Service



Deborah Sullivan - CHI 0712726128

Greater Glasgow
and Clyde

Flat 1/1, 34 Pendene Place, Glasgow, G33 4UG

Caledonia House
140 Fifty Pitches Road
Cardonald Business Park
GLASGOW G51 4EB
Direct Dial: 0141 616 6216
Fax: 0141 616 6201

e-mail: peter.livingstone@nhs.net

Dear Colleague,

I would be extremely grateful for your assessment & advice of this 45-year-old lady. She has a significant PMHx. of chronic pancreatitis. She was reviewed by my colleague on Satay (21/1/18) @ teatime in relation to abdominal pain. She was given Im Diclofenac. Unfortunately, this has made no improvement to her symptoms. I note that she has a PMHx. of fibrinolytic & is taking potent analgesia as well at present. Bowels are loose but no urinary symptoms or pyrexia.

T 37.0°C.

SpO₂: 98%
P: 114 bpm

BP: 132/74

CRP < 2mg/L

 Liver ++, galbladder +.
No masses / enlarged.
BS ✓ +.

D: Ante on chronic pancreatitis

I have given her Im Tramadol 100mg @ 00:45. However in light of her per pain control I would value your opinion.

Many thanks,

Dr Peter Livingstone
MB ChB DGM DRCOG PGDip (Diabetes) MRCP
General Practitioner - GMC No: 6148097

Call No: 5267585	CHI: 0712726128	Date: 21-01-2018	NHS 24 No: 20422619
Patients Name: Deborah Sullivan	D.O.B: 07/12/1972 Age: 45 years	Callers Name: Deborah Relationship:	
Address Today: 6 Muirhead Court Baillieston Glasgow	Home Address if different: 6 Muirhead Court Baillieston Glasgow		
Post Code: G69 7EP	Post Code: G69 7EP		
Phone Number: 07713 718392	Call Type: Home Visit Within 1 Hr Priority: Pr 1 Within 1 hr		
Name of GP:	Time Call Received at NHS 24: 21/01/2018 23:45:20		
Surgery: 222 Baillieston Health Centre Practice Number: 0141 531 8050 Speed Dial: CONTACT DETAILS (.) SPEED DIAL(108) (.) PRACTICE(0141 531 8050) (.) MORNING FAX(0141 531 8067)	Time Details Received at GEMS: 21/01/2018 23:54:00 Time Patient Arrived: Consultation Start time: Consultation End time:		

Dispatched To:

Clinical Information

Examination Results:

Clinical summary created by: Alison Campbell (Usc Call Taker) () [21/01/2018 23:54:13]
Reason for call: ABDO PAIN- 10 HRS. RETURN CALLER: GP HAS ATTENDED AND GIVEN PAIN INJECTION- 5 HRS. PAIN WORSE
Confirmed Symptom(s):
Pale, cold and skin is clammy to touch
Pain above the belly button and over 25 years old
Feeling nauseated or vomiting
Pain moving through to the back
21:01:2018 23:52:27 CAMPBELL A3.. DW TL B CANNON. GP HOME VISIT 1 HR, DUE TO PAIN LEVEL.. GP ATTENDED EARLIER AND GAVE DICLOFENAC INJECTION AND LEFT NAPROXEN, NOT HELPING. PATIENT NORMALLY GETS DIAMORPHINE INJECTION FOR PAIN...
Outcome: Home Visit within 1 Hr

ABDO PAIN - 10 HRS. RETURN CALLER: GP HAS ATTENDED AND GIVEN PAIN INJECTION- 5 HRS. PAIN WORSE

Clinicians Notes

Prescription Items:

Clinical Code/s:

Informational Outcome:

Referral:

Consulting Clinician:

Deborah Sullivan
0712726128

Clinical History : 45 year old lady with known Chronic opancreatitis, appendicectomy, cholecystectomy, fundoplication. Presented with 4/7 epigastric pain radiating to back. Tender on palpation. WCC 14.7. Please could we request a CTAP ?Pancreatic Necrosis/Pancreatic Collection

CT Abdomen and pelvis : Contrast enhanced CT abdomen pelvis. Comparison made with examination dated 31/07/2017.

No free abdominopelvic fluid or gas demonstrated. Surgical clips at the gastro-oesophageal junction in keeping with previous fundoplication. Cholecystectomy clips noted.

Normal pancreas. No peripancreatic inflammatory fat stranding, pancreatic mass or collection. Normal calibre pancreatic duct. Normal calibre post cholecystectomy common bile duct, measuring 8 mm. Normal spleen, adrenals, kidneys, liver and biliary tree. Patent portal vein and its branches, splenic vein and superior mesenteric vein. Patent coeliac trunk, superior mesenteric artery and inferior mesenteric artery. Unremarkable appearance of the included unprepared large and small bowel. No lymphadenopathy.

Appropriately positioned intrauterine device noted. 3.3cm left ovarian cyst noted with simple appearances on CT - likely physiological.

Unremarkable included lung bases and bones.

Impression: No cause for pain demonstrated on CT.

1st Reporter: Dr Sarah MacPherson (ST2)

2nd Reporter: Dr David Cowell (Cons)

Last Verified By: Dr David Cowell (Cons)

Immediate Discharge Letter

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dr. G MacAllister
McGlone Practice
Baillieston Health Centre
20 Muirside Road Baillieston
Glasgow
G69 7AD

Main Switchboard: 0141 211 4000
Date of Completion: 18/11/2017

Dear Dr G MacAllister,

Name	CHI	DoB	Address
Deborah Sullivan	0712726128	07/12/1972	"6 Muirhead Court" Glasgow G69 7EP

Admitted	Type	Discharged	Destination
13/11/2017-01:46	In Patient	13/11/2017	

Specialty	Consultant	Ward	Telephone
General Surgery	Ms Martha Quinn	GRI Ward 65 General Surgery	0141.211 5060

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Doctor,

Deborah Sullivan is a 44 year old lady who was admitted to GRI surgical department on 13.11.17 under the care of Miss Quinn.

She has a complex surgical history, with previous fundoplication and subsequent anterior wrap, cholecystectomy, appendectomy and chronic abdominal pain. Her last OGD in 2015 showed oesophageal spasm/gastric dysmotility.

She presented on this occasion with 12 hours of epigastric pain, radiating to the back. She felt nauseated with no vomiting. Blood tests and observations were normal. On examination, abdomen was soft and non tender, with no palpable masses or hernias.

Abdominal XR showed faecal loading. She was treated with laxatives and enemas. Her bowels moved and her pain settled. She was deemed medically fit for discharge on 13/11. No routine surgical follow up required.

Thank you for your continued care of this patient.

Yours Sincerely,

Alison Martin, FY1 General Surgery, GRI

Treatments: None recorded.**Follow-up arranged:** no routine follow up required.**Planned Outpatient Investigations:** nil**Final Discharge letter to follow:** es**Medication Info:****Allergies:****Height:** cm**Weight:** kg**Discharge Medication:**

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
----------	-------	------	-----	-----------	----------	------------------

Discontinued Medication:

Drug Name	Dose	UOM	Reason
-----------	------	-----	--------

Yours sincerely,
Dr Alison Martin2
Doctor

Prescription Review

Medications Reviewed by Pharmacist:

Dispensed Medications Checked by Pharmacy:

Nurse discharging patient: Alison Martin2, Doctor



CHI: 0712726128

Glasgow Royal Infirmary

Total Att: 26

12 Mth Att: 6

Title: MS

SULLIVAN

Deborah

DOB: 07/12/1972

Age: 44y

Sex: Female

*Daughter
Courtney Kelly*6 Muirhead Court
Baillieston
Glasgow
LanarkshireNext of kin: SULLIVAN, KATHLEEN
Relationship: Parent
0141 771 3743

G69 7EP

GP: G MacAllister

07713718392

0141 531 8050

Shood's

Attendance Date: 13/11/2017

Arrival Time: 00:50

Registration Time: 00:50

Date of Incident: 12/11/2017

Major Incident Desc:

Reason for Attendance: unwell adult

*couldn't get
access*

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 13/11/2017 00:52

Nurse name: Nurse Andrea Willox

Temp	36.2	C
HR	101	bpm
BP	145/123	mmHg
MAP	130.33	mmHg
RR	22	bpm
SpO2	99	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: *SFT* ?pancreatitis, abdo pain ++ hx of same NEWS-3

0712726128
SULLIVAN
Deborah

07/12/1972

0712726128
SULLIVAN
Deborah

07/12/1972

0712726128
SULLIVAN
Deborah

07/12/1972

0712726128
SULLIVAN
Deborah

07/12/1972

0712726128
SULLIVAN
Deborah

07/12/1972

Patient Information		Incident Date: 13/11/2017	 Scottish Ambulance Service
Deborah SULLIVAN		Incident Number: CR004178807	
Age/Gender: 44 years 11 months 6 days Old Female		Incident Type: EMG	
Address: 1/1 34 PENDEEN PLACE BARLANARK GLASGOW, G33 4UG		Incident Location: 1/1 34 PENDEEN PLACE BARLANARK GLASGOW, G33 4UG	
DOB: 07/12/1972			
CHI: 0712726128			
Ethnicity:			

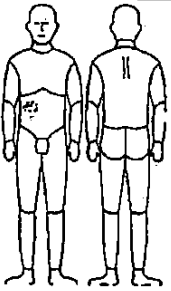
Presenting Complaint

ABDOMINAL PAIN

Additional Comments

999 CALL, UPGRADED URGENT CALL, 44 YOF SUFFERS FROM PANCREATITIS, GP HAS BEEN OUT TO SEE PT, GIVEN X2 30/500 CO CODAMOL AT 2200 HOURS, THIS HAS NOT HELPED PAIN, HASNT VOMITTED, PAIN HAS BEEN CONSTANT SINCE 1400 HOURS. GP LETTER WITH PT. CONS AND ALERT AT HOSP

PATIENT ASSESSMENT

AVPU	Alert		<C>	No
A	Clear			
B				
C	Pulse Rate 110	BP 108/70	Cap Refill ≤2 Secs	ECG Rhythm
	Rhythm Reg	Arm	Central/Peripheral	ECG
D	GCS 15	Eyes Spontaneously (4)	Voice Orientated (5)	Motor, Obeyes Commands (6)
E	PEARL Yes			
				
Pain				
ID	Body Part	Pain Scale		
P1	Abdomen	10		

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrowID
00:26	110	18	108/70	98	≤2 Secs	15	Alert		36.8			4	4		E9888048

NEWS

Time	Clinical Risk	NEWS
00:26	LOW Immediate Clinical Risk. Treat as per Clinical Practice Guidelines including considering the use of alternative pathways (if appropriate and available).	2

Drugs**HISTORY****AMPLE**

Allergies	PENICILLIN
Medication	WITH PT
Past Medical History	PANCREATITIS, GALL STONES, FIBROMYALGIA
Last Eaten	>4 Hours Ago

10/19/2017

Incident Number: CR004176877

Events Prior AT HOME

Social History

Lives alone Yes Patient Occupation Does Not Work

Patient's General Appearance Normal

Patient Mobility Fully Mobile

Patient Communication No Help Required

Patient Clinical Risk Factors None Identified

Patient Environmental Risk Factors None Identified

CLOSE RECORD

Treatment On Scene Non Emergency

Conveyance

Transport To Hospital Normal driving Pre Alert No

INCIDENT LOG

Time Call Received 23:29 Allocated 00:11 Mobile 00:11

First Resource On Scene Crew On Scene 00:19 Crew Left Scene

Crew At Hosp Receiving Hospital Clear Time

Crew ID

Crew Grade

Driver

E9888048

Student Technician Level 3

YES

E0034762

Paramedic

NO

See Surgel Recy,

May Pls for seeing the patient

Amir - Castleline Pancreas, 1BS, Funderplichy
Diet controlled DM.

O/E

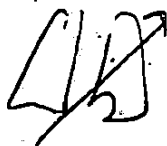
HR 113

eds 98%

BP 108/70

T 36.8

RR 22



Tender throughout
abdomen
BS active

Wp Δ Pancreatitis

Plm - admit Surgeons

- STAT X2 co-coded 30/500 @ 2200

- The Ambulance hased

Handwritten signature

Call No: 5194238	CHI: 0712726128	Date: 12-11-2017	NHS 24 No: 20141001
Patients Name: Deborah Sullivan	D.O.B: 07/12/1972 Age: 44 years	Callers Name: Deborah Relationship:	
Address Today: 1/1 34 Pendeen Place Glasgow	Home Address if different: 6 Muirhead Court Baillieston Glasgow		
Post Code: G33 4UG	Post Code: G69 7EP		
Phone Number: 07713 718392	Call Type: Home Visit Within 2 Hrs Priority: Pr 2 Within 2 hrs		
Name of GP:	Time Call Received at NHS 24: 12/11/2017 21:21:49		
Surgery: 222 Baillieston Health Centre	Time Details Received at GEMS: 12/11/2017 21:34:24		
Practice Number: 0141 531 8050	Time Patient Arrived:		
Speed Dial: CONTACT DETAILS () SPEED DIAL(108) () PRACTICE(0141 531 8050) () MORNING FAX(0141 531 8067)	Consultation Start time: Consultation End time:		
Dispatched To: KIT15			

Clinical Information

Examination Results:

Clinical summary created by: Michelle Crawford (Usc Call Taker) () [12/11/2017 21:33:51]

Reason for call: ABDO PAIN - 8HRS

Confirmed Symptom(s):

Pain above the belly button and over 25 years old

Changes in normal breathing pattern

Pain moving through to the back

12:11:2017 21:23:00 CRAWFORDM.. ABDO PAIN ABOVE THE BELLY BUTTON - PAIN KILLER NO EFFECT - PAIN RADIATES TO BACK AND SHOULDERS - H/O PANCREATITIS - NAUSEA.. BREATHING FASTER DUE TO PAIN.. D/W TL N.REED - USUAL PAIN EXPERIENCE AND TYPICAL PAIN OF PANCREATITIS - UNABLE TO WALK DUE TO PAIN - DR USUAL VISITS WHEN THIS HAPPEN TO ADMINISTER INJECTION TO HELP PAIN - GP HV 2HRS.. OUTCOME - GP HV 2HRS - PLEASE SEE URGENTLY DUE TO LEVEL OF PAIN - AS PER CLINICIAN..

Outcome: Home Visit within 2 Hrs

ABDO PAIN - 8HRS

Clinicians Notes

Prescription Items:

Clinical Code/s:

Informational Outcome:

Referral:

Consulting Clinician:

Date & Time 13/11/17 0230 Consultant Miss Quinn Ward 65

Ward Review

Check List

Bloods ☐
BHCC: +ve ☐ -ve ☐ N/A ☐
Urinalysis ☐
ECG ☐
CXR ☐
AxR ☐
VTE prophylaxis ☐
Med Rec ☐
Kardex ☐

Spl Whalen
44 ♀
~~known to general surgery over the years~~
~~with pan GT motility disorder~~
Prenian fundoplication and subsequent
anterior wrap (2004)
last OGD 2015: oesophageal spasm /
gastric dysmotility
Cholecystectomy, 2006 2006 pancreatitis
Chronic abdominal pain Appendectomy

Meeds

Cyclizine - 12° epigastric pain - back
Lactulose - Nauseated
Diazepam - no vomiting
Esomeprazole - Intermittent waves of pain
Senna - Similar episodes in the past
Duloxetine - Very much like gall bladder pain
Pregabalin - Barely regular & laxatives
Ramipril - need to pass urine more in last few weeks
Rizatriptan o/s
Aripiprazole well
Simvastatin
Naproxen soft
Temazepam
Ceftriaxone sulphate No hernias
Tolterodine

Imp Abdo pain ? cause

Plan urine dip

E+D

AXR

Bloods pending

[Signature] MPATG
13288

Ward Review

13/11/17 NR QUINN

0850

Hx revisited. CRP 4 WCC 11.2.

a/w amylase.

Prev. cholecystectomy + appendectomy

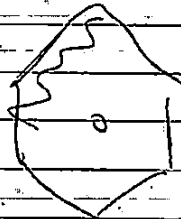
Patient Name

DoB

Unit Number

or affix label

Plan: laxatives

IF BNO / not settling
CTAP.

Soft

Tender

NR Quinn

PRINT NAME

DESIGNATION

SIGNATURE

DATE & TIME

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

(excluding orthopaedics, obstetrics & ENT who have speciality-specific policies)



- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

Pt Addressograph

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐

No ☐

Does the patient have any risk factors for thrombosis? (tick $\checkmark$ all that apply)

Age >60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI >30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick $\checkmark$ all that apply)

Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia
Acquired bleeding disorders (e.g. liver failure) ☐	• Expected within the next 12 hours
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	• Within the previous 4 hours ☐
Acute stroke (within 14 days) ☐	Other procedure with high bleeding risk – discuss with senior if unsure ☐
Persistent uncontrolled hypertension (BP $> 230/120$ mmHg) ☐	Acute bacterial endocarditis ☐
Thrombocytopenia ($<75 \times 10^9/l$) ☐	Surgery expected within the next 12 hours ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Trauma with high bleeding risk e.g. Head Injury ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	eGFR <30 ml/minute/1.73m ² : Dose reduction required ☐
	Heparin induced Thrombocytopenia ☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐

*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

(on day of surgery, at the later of either 4h post-op or 6pm)

Reduce Enoxaparin to 20mg if <50 kg or eGFR <30 ml/minute/1.73m² ☐

If weight > 120 kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

- Peripheral neuropathy ☐
- Peripheral arterial disease ☐
- Cellulitis or Gross oedema ☐
- Leg deformity or Fragile skin ☐
- Leg / foot ulcers ☐
- Allergy ☐
- Unusual leg size/shape ☐

Risk assessment result – please tick $\checkmark$ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient Informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____

Signature: _____

Date: _____

Medicine Reconciliation Form

Source of information:

ECS ☒ 1

Patient ☒ 1

Relative/
carer ☐

GP ☐
surg ☐

GP computer
printout/letter ☐

Patient's
own drugs ☐

Patient Name

DoB

Unit Number

or affix label

Other (specify) unreconciled
none (PAN)

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				Reason for alteration
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	
Cyclizine	5mg	3x	PO				✓	
Lactulose	15ml	BD	PO				✓	
Paracetamol	1g	QDS	PO				✓	
Diazepam	5mg	BD	PO				✓	
Esomeprazole	40mg	BD	PO			X		Not using - pt states was stopped
Senna	15mg	ON	PO				✓	
Duloxetine	60mg	BD	PO				✓	
Probiotics	30mg	BD	PO				✓	
Ramipril	2.5mg	BD	PO				✓	
Risperidone	1mg	ON	PO				✓	PAN
Art. glucose	25mg	BD	PO				✓	
Simvastatin	20mg	ON	PO				✓	
Naloxone	50mg	BD	PO				✓	
Temazepam	1mg	ON	PO				✓	
Quinine sulphate	200mg	ON	PO				✓	
- codeine phosphate	60mg	4/6	PO			X		2/11/17 on DNC
Allergies/adverse events								
Penicillin → rash.								

List obtained by KATIE HUGHES Designation RM

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☒ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist [Signature] Pharmacist [Signature] Date and Time 12-4pm
13/4/17

Comments
pt confirmed used both diazepam + temazepam nocte.
#13914

Clinical Notes

Patient Name

DoB

Unit Number

or affix label



CHI: 0712726128

Glasgow Royal Infirmary

OPR

Total Att: 24

12 Mth Att: 5

Title: MS

SULLIVAN

Deborah

76 kg

DOB: 07/12/1972

Age: 44y

Sex: Female

6 Muirhead Court
Baillieston
Glasgow
LanarkshireNext of kin: SULLIVAN, KATHLEEN
Relationship: Parent
0141 771 3743G69 7EP
07713718392GP: G MacAllister
0141 531 8050

Attendance Date: 31/08/2017 Arrival Time: 14:32

Registration Time: 14:32 Date of Incident: 31/08/2017

Major Incident Desc:

Reason for Attendance: 140 paracetamol last week still has abdo pain

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 31/08/2017 14:49

Nurse name: Nurse Karen Kerr

Temp	36.2	C
HR	112	bpm
BP	114/77	mmHg
MAP	89.33	mmHg
RR	18	bpm
SpO2	97	%
Oxygen		%

BM	6.6	mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS:	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: o/d of 140 paracetamol 6/7 ago, stated this to psychologist today. c/o ruq pain. news

2

0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah

To be Completed by Clinician

Child Assessment Questionnaire

		Yes	No
Previous attendance (considering previous presentations)			
History variable between accounts	0712726128 SULLIVAN F		
Examination not compatible	Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire		
Delay in presentation			
Fracture / head injury	G69 7EP file toddler		

Discussed

any factors identified

Date	Clinical Seen By	Time Seen

Printed: 31/08/2017 17:35:49

Patient Sample Report

Status: **ACCEPTED**
 Analyzed: 31/08/2017 17:35:41
 Sample Type: Venous
 Account Number:
 Clinician: MCFADYEN
 Operator ID: ALASDAIR MCFADYEN

Patient
 ID: 0712726128
 Last Name: SULLIVAN
 First Name: DEBORAH
 Gender/Age: Female, 44 years
 Birth Date: 07/12/1972

Cartridge
 Lot No.: 170705B
 S/N: 000000000400009751
 Exp. Date: 14/09/2017

Analyzer
 Model: GEM® Premier 5000
 Area: GRI
 Name: CASU
 S/N: 16090423

Results

Results			Crit. Low	Reference		Crit. High
Measured (37.0°C)			Low	Low	High	High
cH	39.4	nmol/L	[--	--	--	--
pCO ₂	7.1	kPa	[--	--	--	--
pO ₂	5.9	kPa	[--	--	--	--
Na ⁺	137	mmol/L	[--	--	--	--
K ⁺	4.3	mmol/L	[--	--	--	--
Cl ⁻	105	mmol/L	[--	--	--	--
Ca ⁺⁺	1.19	mmol/L	[--	--	--	--
Glu	4.9	mmol/L	[--	--	--	--
Lac	0.9	mmol/L	[--	--	--	--
CO-Oximetry						
tHb	128	g/L	[--	--	--	--
O ₂ Hb	71.5	%	[--	--	--	--
COHb	3.9	%	[--	--	--	--
MetHb	1.1	%	[--	--	--	--
HHb	23.4	%	[--	--	--	--
sO ₂	75.3	%	[--	--	--	--
Derived						
BE(B)	6.6	mmol/L	[--	--	--	--
HCO ₃ (c)	32.8	mmol/L	[--	--	--	--
Hct(c)	38	%	[--	--	--	--



0712726128
 SULLIVAN F
 Deborah 07/12/1972

Other Information

Operator Entered
 Temp 37.0 °C

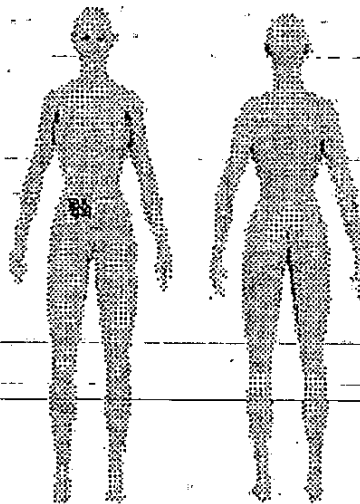
Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
	IBUPROFEN	400mg	PO			
	BUSSOPRAN	20mg	PO			

Scottish Ambulance Service Patient Report Form																			
Incident Number	CR004003976 on 31/08/2017 at 13:00																		
Call sign						Incident Type	EMG												
Crew1	E9887539					Crew3													
Crew2	E9887977					Crew4													
INCIDENT LOG																			
Incident Location	AUCHINLEA HOUSE EASTERHOUSE H/C 9 AUCHINLEA ROAD EASTERHOUSE GLASGOW					Incident Postcode	G34 9HQ												
Call Received	13:00 - 31/08/2017					Patient at Hospital													
Call Passed	13:26 - 31/08/2017					Patient Handover													
Crew Mobile	13:27 - 31/08/2017					Crew Clear													
Crew at Scene	13:34 - 31/08/2017					Clear Reason													
Crew Left Scene	14:01 - 31/08/2017																		
Pre-alert Medical Standby																			
Receiving Hospital	GLASGOW ROYAL INFIRMARY																		
DIAGNOSIS																			
Chief Complaint Code	HCP																		
Despatch Code	33C06 : Emergency Response Requested																		
Diagnostic Code	01A01 : 01A01 - Abdominal Pain																		
PATIENT DETAILS																			
Surname	SULLIVAN																		
Forename	DEBORAH																		
Middle Initials						Sex	Female												
DoB	07/12/1972					Age	44 years 8 months 24 days												
Patient Address						Patient Postcode													
Patient Telephone						Ethnicity													
CHI Number	0712726128																		
PATIENT CONSENT																			
Mental Capacity Assessed	Deemed To Have Capacity																		
Level of Consent	Advice Given To Patient, Risk Of Refusal Explained, Risks Of Condition Explained, Treatment Benefits Explained																		
PRIMARY SURVEY																			
AVPU Assessment	Alert																		
Catastrophic Haemorrhage	No																		
Airway Assessment	Clear																		
Breathing Rate	Normal																		
Respiratory Rate	20																		
Pulse	Fast																		
Most Peripheral Palpable Pulse Found	Radial																		
Skin Colour	Normal																		
Skin Texture	Dry																		
Capillary Refill Rate	< 2 Secs																		
CSI Assessment	None																		
VITAL SIGNS																			
Time	Pulse	Rhythm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	FS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
13:40	107	Reg	Alert	20	116	90	6.6	37.2	97	8	< 2 Secs	Sinus tachycardia	1	15	6.6	1			
13:53	111	Reg/r	Alert	18	116	90			98		< 2 Secs	Sinus tachycardia	1	15	7.8	2			
AMPLE																			
Allergy Type	Antibiotics, PEMECILLIN																		
Previous Medication	DULOXETINE, PREGABALIN, OMEPRAZOLE, DIAZEPAM, ZOPICLON, SYCLAZINE																		
Previous Medical History	FIBROMYALGIA, GALLSTONES, PANCREATITIS																		
Last Eaten Before Incident	5 Hours																		
Events Prior To Incident	ABDO PAIN SINCE 140x500MG PARACETAMOL O/D LAST FRI																		
MEDICINES																			
Drug	Time	Dosage	Route	Crew No	Batch/Expiry	Pain Before	Pain After												
Entonox	13:50		Inh	E9887977		8	6												
INJURIES																			



PAIN	P1	No Pain Relief Provided
------	----	-------------------------



EMERGENCY SERVICES

In Attendance Doctor, Technician

PATIENT HANDOVER

Patient Mobility On Arrival Standing

On Scene Removal

Patient Transportation Seated

Care Delivery At Hospital

Chair

Time Of Patient Handover

SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
107	20	116	37.2	15	6.6	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
111	18	116		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
13:40	Spontaneous	Orientated	Obeys Commands	15
13:53	Spontaneous	Orientated	Obeys Commands	15

SOCIAL ASSESSMENT

Patient Age	
Situation	
Risk Assessment	Low Degree Of Risk
Action Taken	Patient Conveyed To Hospital
Additional Details Of Risk Or Concern	

SAFEGUARDING

Situation	Patient Aged Over 45, Patient Lives Alone
Previous History Of Mental Health Problems	History Of Depression, History Of Other Mental Health Problems
Action Taken	
Details Of Risk Or Concern	

DYNAMIC RISK ASSESSMENT

Previous Warning Of Risk		Warning Of Immediate Risk	
Warning Of Possible Risk			
Risk Assessment	Low Degree Of Risk		
Special Hazards			
Other Risks or Hazards			

ADDITIONAL COMMENTS AND OBSERVATIONS

999 CALL TO 44 YOF WITH ABDO PAIN, OA AT GP SURGERY PT ALERT TO TIME AND PLACE, GCS 15, OE SLIGHT TACHYCARDIA 111 BPM, OTHER OBS UNREMARKABLE. PT TOOK 140x500MG PARACETAMOL LAS FRI IN AN ATTEMPT AT TAKING HER OWN LIFE. PT HAD HAD RIGHT SIDED ABDO PAIN SINCE STATING A PAIN SCORE OF 8. PT WENT TO PLANNED APPOINTMENT WITH PSYCHOLOGIST TODAY AND MENTIONED ABOUT OVD. GP ADVISED TRANSFER TO A&E FOR CHECK UP. PT STATED PAIN SCORE OF 8, GIVEN ENTONOX PAIN SUBSIDED TO SCORE OF 6. PMX PSYCHOSIS, PANCREATITIS, GALLSTONES, FIBROMYALGIA.

REPORT MANAGEMENT

Report ID	CR004003976-31082017140937
Software Version	1.0.444
Report Type	Interim

Contact number: 0141 232 7200

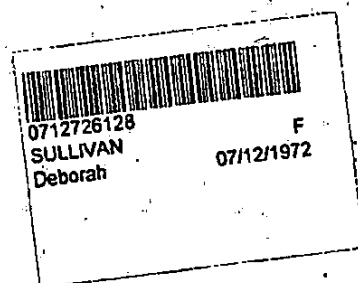
Our Ref: LH

Date Typed: 31st August 2017

Private and Confidential

Accident and Emergency
GRI

Re: SULLIVAN, Deborah (Ms)
071 272 6128
6 Muirhead Court
Baillieston
Glasgow
G69 7EP



Dear colleagues,

Deborah attended a planned appointment with one of my psychology colleagues today.

She disclosed a Paracetamol overdose taken on Friday with suicidal intent at that time. 140 x 500mg tablets

She complains of intermittent abdominal pain.

PMHx = Fibromyalgia, gallstones, pancreatitis.

O/E:- ACD 15, warm and well perfused.

BP 120/96, HR 110 regular.

DEBORAH SULLIVAN. cont: -

HS I+II TO, no oedema, no calf tenderness.

Chest ~~clear~~ not examined

Abd soft, tender epigastrium + RUQ.

no guarding, no rebound.

BS ✓

My colleague contacted SAT as per our procedure.

She has ongoing psychiatric follow-up planned via the CMHT.

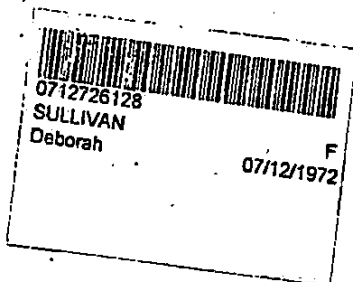
I am grateful for your physical assessment with regards to whether she requires treatment in this overdose.

Many Thanks,

UAE

LEAH MAWSON

SPECIALIST DOCTOR IN PSYCHIATRY.



Transfer letter:



Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Parkhead Hospital

Main
Switchboard:
Department:
Contact Tel:
Enquiries to:
Letter Date: 01/09/2017
Reference:
Dictated 01/09/2017
Date:
Transcribed
Date:

Dear Doctor,

Deborah Sullivan; D.O.B: 07/12/1972; CHI: 0712726128
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Background:- Fibromyalgia, anxiety, depression, previous sexual assault, chronic pancreatitis, previous cholecystectomy

Diagnosis:-

1. Intentional paracetamol overdose

This 44 year lady presented to the GRI admitting that she had taken an intentional paracetamol overdose. She said that she had taken 140 paracetamol tablets 6 days ago over a period of 8 hours. She thought that she would die but did not write a suicide note or leave any goodbye messages. She was not drinking alcohol at the time. Her blood tests including liver function tests and coagulation were normal. Her paracetamol level was 5 and so treatment was not commenced.

She was reviewed by liaison psychiatry and agreed to be transferred to Parkhead hospital for further psychiatric assessment. She is medically fit for transfer.

Thank you for your continuing care,

Joshua Mrode, FY1 Medicine

Electronically Signed:

cc.



0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP
F
07/12/1972

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow
and Clyde

0712726128
SULLIVAN
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐	G+S ☐	X-match	units		
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other
CXR ☐	AXR ☐	Other imaging:						ECG ☐
Current location:							Sent by:	

Clinical Notes

Date 31/8 Time 1630 Name mclachlan Grade FELLOW Specialty EM

PC ? paracetamol OD

Background

- fibromyalgia
- anxiety
- depression
- chronic pancreatitis
- prev sexual assault
- prev cholecystectomy

HPC

> revealed to psychologist today that she had taken an overdose of paracetamol

> alleges to have taken 140 ~~500~~ms paracetamol tablets 6/7 ago

> staggered OD over 8 hours

> took as felt daughter "would be better off" without her.

- also scared as daughter would not be there over the weekend

Glasgow Royal Infirmary
Emergency Department

0712726128
SULLIVAN
Deborah 07/12/1977
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Clinical Notes

Date 3/18 Time 1645 Name mcladgen Grade FELLOW Specialty EM

- suicide note
- goodbye texts
- alcohol involved

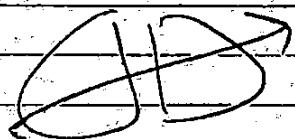
states normally has auditory hallucinations
- voice of men who attacked her
told her to do this.

since overdose has been having RUQ
pain

- radiates to back
- constant
- assoc diarrhoea
- ◦ jaundice
- ◦ bruising
- ◦ fever
- ◦ vomiting
- not taken analgesia
- 5/10.

- has CMHT FIU in place next
week w/ psychologist
- supported by daughter who
stays w/ her.
- regretful of actions.

PE APU

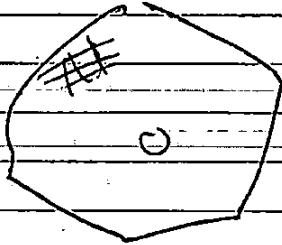


HS HT
CRIC 2 sec



Clinical Notes

Date 31/8 Time 1645 Name metadon Grade FELU Specialty SM



↑ body habitus ++
soft
RLQ tenderness
BSHe

° jaundice
° murphy sign

bloods: paracetamol 5
ALT 177

as per toxbase requires treatment

(P) W access
bloods
psychiatric assessment post Rx
parvolex Rx
admit medicine

**Glasgow Royal Infirmary
Emergency Department**

0712726128
SULLIVAN
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

HAEM	DATE of TIME	BIOCH	DATE of TIME		DATE of TIME	V/ABG	DATE of TIME
WCC	9.7	Na		Bil	9	FiO ₂	
Hb	135	K		ALT	177	H ⁺	
Plat	404	Cl		AST	27	PaCO ₂	
Neut		Ur	30	GGT		PaO ₂	
DD		Creat		A phos	67	Bic	
PT	11	eGFR		Alb	39	BE	
PTT		Glu		AdjCa		Lactate	
TT		CRP		Amyl		Ethanol	
INR		Mg		TropI HS		Para	5
		Phos		BHCG		Sal	

Diagnosis and Plan

Review/Discussed with:	Handover
	☐ Provisional Diagnosis
	☐ Liquids/Fluids
	☐ Analgesic/Medicines
	☐ NEWS
	☐ Investigations & Results
	☐ Talk to receiving team/ward

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)

NHS
Greater Glasgow
and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

G69 7EP

Date & Time 21/8 18:40 Consultant

Ward 50

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
Med - Rec ☐
Kardex ☐
CXR ☐
ECG ☐
Oxygen ☐
Patient on
Bleeders list ☐

PL - Paracetamol OD
Is took 140 tablets paracetamol
last Friday (6 days ago)

Seen directly by medical
consultant → see post take

Ward Review

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific]



- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
07/12/1972
G69 7EP

Operative patients **Non-operative patients**

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick $\checkmark$ all that apply)

Age >60 ☒	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI >30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes; 1 or more risk factors identified ☒

No risk factors identified ☐

Indicators of high risk bleeding (tick $\checkmark$ all that apply)

Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia
Acquired bleeding disorders (e.g. liver failure) ☐	• Expected within the next 12 hours
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	• Within the previous 4 hours ☐
Acute stroke (within 14 days) ☐	Other procedure with high bleeding risk - discuss with senior if unsure ☐
Persistent uncontrolled hypertension (BP $> 230/120$ mmHg) ☐	Acute bacterial endocarditis ☐
Thrombocytopenia ($<75 \times 10^9/l$) ☐	Surgery expected within the next 12 hours ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrand's) ☐	Trauma with high bleeding risk e.g. Head Injury ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	eGFR <30 ml/minute/1.73m ² : Dose reduction required ☐
	Heparin induced Thrombocytopenia ☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☒

Contraindications to pharmacological prophylaxis identified ☐

Operative patients - Enoxaparin 40mg + AES ☒
*prior to application of AES, please check contraindications to AES
Non-operative patients - Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
(on day of surgery, at the later of either 4h post-op or 6pm)
Reduce Enoxaparin to 20mg if <50 kg or eGFR <30 ml/minute/1.73m² ☐
If weight > 120 kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result - please tick $\checkmark$ all that apply

VTE risk factors: YES ☒ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☒ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☒ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information:

ECS ☒ (N)

Patient ☒

Relative/
carer ☐

GP ☐
surg ☐

GP computer
printout/letter ☐

Patient's
own drugs ☐

Other
(specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
Amitriptyline	30mg	OD	PO				☒	Pt states increased to 30mg nocte
Sumatriptan	50mg	PRN	PO				☒	if migrate
Lactulose	15ml	OD	PO				☒	
Paracetamol	1g	QOS	PO	☒				STOP -> OVERDOSE
Pregabalin	300mg	BD	PO				☒	
Duloxetine	60mg	BD	PO				☒	
Zopiclone (7.5mg)	3.75	ON	PO				☒	Pt states takes 2x 3.75mg
Diazepam	5mg	OD	PO				☒	also takes depending on anxiety
Sumatriptan								
Senna	11	OD	PO				☒	
Tolterodine	2mg	OD	PO				☒	Pt no longer takes (dry mouth)
Quinine sulfate	600mg	OD	PO				☒	
cyclizide	50mg	OD	PO				☒	
Ramipril	2.5mg	OD	PO				☒	
Trafalgar Heat	1app	TID	TOP				☒	rev if required
Esomeprazole	40mg	BD	PO				☒	
Naproxen	250mg	BD	PO				☐	rev if required.
Allergies/adverse events				Penicillin				

List obtained by

M. Bussan

Designation

Recently altered/discontinued medicines prior to admission and reasons why

Compliance aid?

Y ☐

N ☒

Type

If, Y Community Pharmacy

Phone

Senior Medical staff review: Sign

Title

Date and Time

Reviewed by pharmacist R. SHANNON # 11054

Date and Time 1/9/17

Comments

- Please riv pt states amitriptyline recently increased to 30mg nocte as per neurology
- Patient no longer takes Tolterodine → please riv
- patient usually takes zopiclone 7.5mg nocte (as per ECS) → please riv.

Consultant Review *Gussie*

(44) Known to psych.
+ Fluoxetine / cholestyramide.

Attended planned psych appt today
and disclosed paracetamol O.D.
~150 tabs 6/7 ago

- took 2 suicidal intent / orgy.
- no further paracetamol eating tabs
= since then.

Felt vomited / abdo discomfort since
but no vmtg + PU'ng.

O/E. GCS 15. Good eye contact / amiable
shere.



0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

07/12/1972

G69 7EP

Tender RVD.
Abdo 1/1+ } significant
✓

Guardedness

PT (N)

LA (N) bar A7 177

UE (N)

Paracetamol level = 5.

Imp. No convincing evidence of
significant P.O.D. / sig.
liver / renal dysfunction.
Stop paracetamol.

Check List

VTE ☐
Med - Rec ☐
Kardex ☐
CXR ☐
ECG ☐
Oxygen ☐

EDD

PRINT NAME *Gussie*

SIGNATURE

DESIGNATION

DATE & TIME

3/8/17

Clinical Notes

31/08/2017 NURSING

1850 Admitted to ward 57
from A&E with delayed
presentation of paracetamol
overdose.
WOK aware of admission.
No complaints at present

SIN A. MURPHY

Along 01/09/17 @ 0415

c/o migraine and became tearful
~~sedated~~ Scopolamine given PRN with
good effect as patient settled and
slept thereafter
news 0, obs stable as charted
for psych review in am

C. MURPHY

19110- W. SMITH
1025

(44) ALLEGED PARACETAMOL OVERDOSE
+ ANXIETY (DEPRESSIVE)
FIBROMYALGIA
PRN TREATMENT REQUIRED

0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

F
07/12/1972

G69 7EP

TEARFUL

Agree - unlikely significant paracetamol O.D.
MCP

W RIV

med fut per D/C

lyfe

Clinical Notes

Liaison Psychiatry 1/9/17

Assessed on ward today, Very distressed, crying throughout assessment.

Continues to claim she took 100 paracetamol tablets 6/7 ago but no medical issues noted.

She states she is struggling to cope at home. She had no keys at assessment and continues to express a wish to be dead. She states she "will do something else" but no specific plans.

We discussed this & ultimately were left with no alternative but to suggest admission to Inpatient Psychiatry.

We have contacted the Bed-Manager at Parkhead hospital and she should be transferred to ward 3 Parkhead hospital when medically fit.

C. McLaughlin

01/09/2017 Nursing

1215

Settled at present.

Independent with personal care observations as checked.

NEWS score = 0

Medications given as prescribed.

For transfer to Ward 3 - Parkhead today.

S. A. Martin



0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

F
07/12/1972

G69 7EP

Clinical Notes

01/09/2017 nursing

12²⁰

Handover given to ward 3
at Parkhead.
Patient has contacted NOK
and aware of transfer.
Transport to be arranged.

SIN A. MARTIN

12⁴⁰

transfer letter completed -
transport organised with
Auxiliary escort.

SIN A. MARTIN



0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

F
07/12/1972

G69 7EP

Nursing Admission & Assessment

1. Admission



Hospital: <u>G21</u>	Ward: <u>57</u>
Date of admission: <u>31/05/17</u>	Time: <u>1850</u>
Admitting Consultant:	Admitting Nurse: <u>A-MARTIN</u>
Expected date of discharge: <u>/ /</u>	

0712726128	
Nam: <u>SULLIVAN</u>	F
Adc: <u>Deborah</u>	07/12/1972
<u>6 Muirhead Court</u>	
<u>Baillieston</u>	
<u>Glasgow, Lanarkshire</u>	
Do:	G69 7EP
Chi: <u>11/11/17</u>	
Affix patient data label	

1. Patient Details	
Preferred name:	Next of Kin (NoK): <u>COURTNEY KELLY</u>
Age:	Relationship: <u>DAUGHTER</u>
Religion:	NoK Address:
Telephone: <u>Dr. G MacAllister</u>	
<u>McGloone Practice</u>	
GP: <u>Baillieston Health Centre</u>	NoK Telephone:
<u>20 Muirside Road baillieston</u>	
GP address: <u>Glasgow</u>	NoK Aware of admission: ☐ Yes ☐ No
<u>G69 7AD</u>	Consent for information to be given to relative/carer/friend:
	☐ Yes ☐ No
	Nominated relative/carer/friend contact:
GP telephone:	Telephone - Day:
	Telephone - Evening:

Is the patient a carer? ☐ Yes ☐ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide - Name: Relationship:

Contact telephone number:

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No

If 'Yes' obtain a copy and file with patient notes.

If 'No' to 'b' please inform medical staff. Name of doctor informed:

2. Presenting Complaint / Diagnosis

Have treatment / investigations:

PARACETAMOL OD (DELAYED PRESENTATION)

Why does the patient think they are in hospital? Use patients own words: RUQ PAIN.

3. Allergies (including food allergies)

No known allergies: ☐ *PENICILLIN*

4. Observations

Cannard	Waterflow	MUST	Pulse	BP	Resp	SaO ₂	Temp.
<u>/</u>	<u>PUDRA</u>	<u>0</u>	<u>89</u>	<u>119/78</u>	<u>18</u>	<u>100%</u>	<u>36.4°C</u>
Urinalysis:	BM	NEWS Score	Weight Patient reported for weight/Actual	Height Patients reported height/Actual	BMI		
<u>AWAITED</u>	<u>5-7</u>	<u>0</u>	<u>175cm</u>	<u>5ft 9</u>	<u>26</u>		

5. Current Medication

SEE KARDEx-

6. Relevant Past Medical History

FIBROMYALGIA
ANXIETY
DEPRESSION
CHRONIC PANCREATITIS
PREV. CHOLECYSTECTOMY

7. Risk Assessment

MUST Screening Tool

- Is the patient's BMI:
 - > 20Score 0
 - 18.5-20Score 1
 - <18.5Score 2
- Has the patient had unplanned weight loss in the past 3-6 months?
 - < 5%Score 0
 - 5-10%Score 1
 - >10%Score 2
- If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
 - Score = 2
 - Not applicable: Score = 0

MUST Score: 1

If score 1 or more, complete full Nutrition Profile Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☒ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☒ No

0712726128	
SULLIVAN	F
Deborah	07/12/1972
6 Muirhead Court	
Baillieston	
Glasgow, Lanarkshire	
G69 7EP	

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☒ No If 'Yes' complete the following section.

- Has the patient ever had a previous positive MRSA result? ☐ Yes ☒ No ☐ Not known
- Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☒ No ☐ Not known
- Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☒ No ☐ Not known

If 'Yes' to any of the above questions OR if the patient is admitted to a 'high impact speciality' e.g.

Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:

☐ Nasal ☐ Perineum ☐ Other - Specify: ☐ Patient refused

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☒ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☒ No If 'Yes' obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☒

Lifestyle

Smoking:

Are you a smoker ☒ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop?10CPO

If smoker how many cigarettes per day.....10CPO

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☒ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☒ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☒ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

☐ Never ☐ Less than monthly
☒ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

☒ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): A. MARTIN

Signature: [Signature]

Designation: SN

Date: 31/08/2017

Nursing Admission & Assessment

2. Assessment

Hospital: <u>CLL</u>	Ward: <u>570</u>
Date of Assessment: <u>31/08/17</u>	Time: <u>1830</u>

Name:

Adc: 

0712726128

SULLIVAN

Do: Deborah F

6 Muirhead Court 07/12/1972

Ct: Baillieston

Glasgow, Lanarkshire

G69 7EP

1. Breathing and Circulation

Breathing:

- ☒ No symptoms or history of respiratory problems ☐ Productive / non-productive cough evident
- ☐ Dyspnoeic at rest ☐ Normally receives oxygen therapy
- ☐ Dyspnoeic on minimal exertion If 'Yes' provide details:
- ☐ Dyspnoeic on maximum exertion

Circulation:

- ☒ No symptoms
- ☐ known high blood pressure ☐ known angina ☐ current chest pain

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial



2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

ENGLISH

Interpreter: Required ☐ Not required ☒

If required, provide details and arrangement made:

Does the patient have:

- a. Speech difficulties? ☐ Yes ☒ No
- b. A learning disability e.g. Down's Syndrome? ☐ Yes ☒ No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

☐ Yes ☒ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☒ No

If 'Yes' please specify:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial



3. Senses

Senses:

Eyesight

- ☐ Normal vision
- ☒ Glasses - ☐ Distance ☒ Reading
- ☐ Prosthesis - ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☒ Normal
- ☐ Hearing impaired
- ☐ Hearing aid - ☐ Left ☐ Right

4. Cognitive Status

Cognitive Status:

- ☒ Orientated
- ☐ Confused
- ☐ Distressed
- ☐ Aggressive / Abusive
- ☐ Known dementia
- ☐ Unconscious

5. Hydration and Nutrition

MUST Score: If score is 1 or more, complete a Nutrition Profile.

Nutrition Profile completed ☒ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / /

5a 1. Food likes / dislikes:

Varied

5c. Help needed with eating and drinking:

☐ Yes ☐ No

If 'Yes' provide details:

5a 2. Fluid likes / dislikes:

Varied

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☐ No

If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?

☐ Yes ☐ No

If 'Yes' specify texture: A ☐ B ☐ C ☐ D ☐ E ☐

Thickened Fluids required? ☒ Yes ☐ No

If 'Yes' specify stage required: 1 ☐ 2 ☐ 3 ☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

poor appetite

Initial

[Signature]

6. Elimination

Continent:

- ☒ Bladder
☒ Bowel

Incontinent:

- ☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:

☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No

If Yes is it urethral ☐ suprapubic ☐

If 'Yes' - Size: fg Make:

Date catheter last changed: / /

Continence assessment commenced:

☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☒ Bowels regular

☐ Constipated

☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No

If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

[Signature]



0712726128

SULLIVAN

Name: Deborah

07/12/1972

Address: 6 Muirhead Court

Baillieston

Glasgow, Lanarkshire

DoB:

G69 7EP

CHI number:

Affix patient data label

7. Personal Hygiene, Oral Health and Skin Assessment

Personal hygiene:

- ☒ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Name:
 Address:
 0712726128
 DoB: SULLIVAN F
 Deborah 07/12/1972
 CHI: nur

Oral health:

- Self-caring and independent ☒ Yes ☐ No
 Does the patient have a sore mouth ☒ Yes ☐ No
 Does the patient have a non healing mouth ulcer ☐ Yes ☒ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:

Does the patient wear a denture plate?

- ☐ Yes ☒ No

If yes complete the following:

- ☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

- ☒ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

8. Mobility

Patient fully mobile / independent? ☒ Yes ☐ No If 'No' complete Moving and Handling Assessment.

- ☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:

- ☒ Yes ☐ No

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Recent falls

Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☒ No
 If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☒ No

Bed rails required:

- ☐ Required ☒ Not required

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

0. Sleep and Rest

Sleep habits:

- ☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

- ☐ None ☒ Disturbed
☐ Early waking e.g. nocturia, insomnia

Medication required: ☒ Yes ☐ No

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

1. Social Circumstances

- ☐ Employed ☐ Unemployed ☐ Retired
☐ Health problems at work
☐ Lives alone
☒ Lives with Family (daughter)
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services

Unpaid carer ☐ Yes ☐ No

If Yes are they Partner / Friend / Son / Daughter

What kind of care do they provide?:

- ☐ Private Carers
☐ None

If support services in place, please provide details:

Does the patient have any money worries? ☐ Yes ☐ No

If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?

☐ Yes ☐ No

If Yes please identify date patient referred:/...../.....

Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering

☐ Yes ☐ No

If Yes please identify date patient referred:/...../.....

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☐ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☒ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☒ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☒ Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☒

Is the patient aware of their:

Diagnosis? ☐ Yes ☐ No

Prognosis? ☐ Yes ☐ No

Is the patient's family aware of their:

Diagnosis? ☐ Yes ☐ No

Prognosis? ☐ Yes ☐ No

Preferred place of care:

Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:

Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☒ No

If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): A. MARTIN

Signature:

Designation:

Date:

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
31/08/17 1830	See UPR.	S. A. MARTIN

0712726128
SULLIVAN
Ad Deborah
F
07/12/1972
Dol
CHI
Affix patient data label

Affix patient data label



CHI: 0712726128

Glasgow Royal Infirmary

17

Total Att: 22

12 Mth Att: 3

Title: MS

SULLIVAN

Deborah

DOB: 07/12/1972

Age: 44y

Sex: Female

6 Muirhead Court
Baillieston
Glasgow
Lanarkshire

Next of kin: SULLIVAN, KATHLEEN

Relationship: Parent

0141 771 3743

G69 7EP

GP: G MacAllister

07713718392

0141 531 8050

Attendance Date: 19/07/2017 Arrival Time: 00:13

Registration Time: 00:13 Date of Incident: 19/07/2017

Major Incident Desc:

Reason for Attendance: collapsed adult - daughter in w/r

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 19/07/2017 00:15

Nurse name: Nurse Paul Kane

Temp	37.5	C
HR	114	bpm
BP	146/103	mmHg
MAP	117.33	mmHg
RR	20	bpm
SpO2	98	%
Oxygen		%

BM	9.3	mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: PT worsening frontal headache since approx. 1630hrs. Unrelieved by several doses of migralieve. Photophobic. Recent lx for same, ? migraines.

0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah

To be Completed by Clinician		
Child Assessment Questionnaire	Yes	No
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history / presentation		
Delay in presentation		
Fracture / head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

Date	Clinical Notes
	Seen By Time Seen

--	--

Once Only Prescriptions (Including Tetanus Prophylaxis)

Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By
19/7/11	PARACETAMOL	1g	o	0830		
19/7	Metoclopramide	10mg	PO	3.30		

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow
and Clyde

0712726128
SULLIVAN
2 Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
07/12/1972
F
G69 7EP

Initial Investigations Ordered

FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match	units		
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:							ECG ☐	

Current location:

Sent by:

Clinical Notes

Date 19/7 Time 3:00 Name K Macella Grade F4/2 Speciality A+E

PC, frontal headache - pressure type.

HPC, gradual onset of frontal headache since Friday but worsening today. Feels pain behind eyes and light makes headache worse though allowing torch to be shone in eyes. Complaining of neck pain but from.

Nausea + vomiting

No fevers.

Tingling in (R) arm/leg but no weakness.

Headache worsened today and felt increasingly unwell and reports vague history of collapse where she was lying on the kitchen floor today and had no energy afterwards to get up.

Has been taking Migralene to little effect.

Says has had headaches since having IE in January but not had associated features before.

Glasgow Royal Infirmary
Emergency Department



0712726128
SULLIVAN F
2 Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Clinical Notes

Date 19/7 Time 3.00 Name K McCalla Grade FY2 Speciality A&E

PMH, Chronic pancreatitis 2° gallstones
Anxiety with depression

FH, Sister has meningioma

OH, Duloxetine
Tramadol
Cyclizine
Zopiclone
Lactulose
Paracetamol
Ramipril
Pregabalin
Diazepam
Senna
Quinine
Esomeprazole
Tiotropium

Allergy to penicillins

OTE lying with towel over eyes

A - Patent

B - RR 20

Sats 98%

Chest - Clear



0712726128

SULLIVAN

F

2 Deborah

07/12/1972

6 Muirhead Court

Baillieston

Glasgow, Lanarkshire

G69 7EP

Clinical Notes

Date 9/7 Time 3.00 Name I. McLean Grade F42 Speciality A+E

C - HR 114

Venous gas

BP 146/103

H+ 40.9

HS 1+170

PCO2 5.6

lactate 1.0

O - GCS 15/15

bicarb 25.4

Apyrexia 37.5°C

CN - Intact

PEARL (not ~~not~~ winning by torch light)

Neuro - Intact - full power + sensation

No neck stiffness

Generalized neck pain with FROM of neck.

No non-blanching rash present

Abdo SNT BS+

Imp - ? Migraine

? Intracerebral bleed

? Infection

Ⓟ Analgesia

Anti-emetic

IV fluids

CT head

Bloods.

Admit to medicine for management of headache and ? LP

[Signature]

Glasgow Royal Infirmary
Emergency Department



0712726128
F
SULLIVAN
07/12/1972
2 Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

HAEM	DATE or TIME	BIOCH	DATE or TIME		DATE or TIME	V/ABG	DATE or TIME
WCC	10.8	Na	139	Bil	3	FiO ₂	*
Hb	128	K	4.3	ALT	12	H ⁺	
Plat	313	Cl	106	AST	15	PaCO ₂	
Neut	5.2	Ur	3.7	GGT	-	PaO ₂	-
DD		Creat	56	A phos	61	Bic	
PT	11	eGFR	760	Alb	38	BE	
PTT	30	Glu	5.8	AdjCa	2.34	Lactate	1.2
TT	13	CRP	2	Amyl	109	Ethanol	
INR		Mg		Tropl HS		Para	
		Phos	1.58	BHCG		Sal	

Diagnosis and Plan

CT Head - no acute intracranial haemorrhage,
infarction or SOL.

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)

NHS
Greater Glasgow
and Clyde



0712726128
SULLIVAN
2 Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

07/12/197

G69 7EI

Date & Time 19/1/17 0500 Consultant _____ Ward _____

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
Med - Rec ☐
Kardex ☐
CXR ☐
ECG ☐
Oxygen ☐
Patient on Bleeders list ☐

Brown-Ken CT2

A+E Referral → seen in A+E

(44) Background
+

Chronic Pancreatitis secondary to Gallstones
Nissen fundoplication

T8 Shingles

Chronic Pain

Migraines.

PC Headache

4 day history of gradually worsening bilateral, frontal headache.
No aura. Nausea, some vomiting.

Some intermittent pins + needles down (R) forearm and (L) hip → knee.
No weakness / facial droop / slurred speech.

Taking regular Paracetamol, Pregabalin,
GP advised to stop Tramadol.

No head trauma / LOC / collapse.

No fever, rash, neck stiffness.

Averse to bright lights, but able to tolerate pen torch.
Family well.

No foreign travel.

Headache not worse in morning.

ON no alcohol
usually (F)



Ward Review

Na 139; K 4.3; Chl 106; Urea 3.7; Creat 56; eGFR >60

Bil 3; ALT 12; AST 15; ALP 61; A/G 38

Lactate 1.2; Glucose 5.8; CRP 2

Adj Ca - 2.34 Amylase 109

WBC 10.8; Hb 128; Plt 313

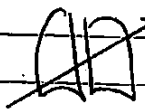
CT Head (Provisional Report)

No acute intracranial haemorrhage.

RR 17, Sat 98% @, Temp 36.5°C, HR 85, BP 137/98 Mews 0

O/E ACS 15 (A/P/H AMT 4/4)

HS 1 + 11 + 10 Regular



clear



SNT
BS

No peripheral oedema

JVP ↓

Oral mucosa.

Cervical SNT.

PERA

CN II → XII intact

	RUL	LUL	RLL	LLL
Tone				
Power	5	5	5	5
Reflex	✓	✓	✓	✓
Coord	✓	✓	✓	✓
Sens	✓	✓	✓	✓

No word finding difficulties

No rashes

No neck stiffness

Not photophobic.

Imp Most likely Migraine

- given frequency of attacks, would benefit from prophylactic agent and Neuro referral.

- may be an Analgesia-overuse Headache

Plan 1) IVF

2) Antiemetics

3) Trial Sumatriptan 50mg OD now

4) Discuss with Neurology

5) Not for LP at present

ARBE CIR

728105

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS

Greater Glasgow
and Clyde

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

	
0712726128	
SULLIVAN	
2 Deborah	07/12/197
6 Muirhead Court	
Baillieston	
Glasgow, Lanarkshire	
G69 7EJ	

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐

No ☐

Does the patient have any risk factors for thrombosis? (tick $\checkmark$ all that apply)

Age >60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI >30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick $\checkmark$ all that apply)

Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia
Acquired bleeding disorders (e.g. liver failure) ☐	• Expected within the next 12 hours ☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	• Within the previous 4 hours ☐
Acute stroke (within 14 days) ☐	Other procedure with high bleeding risk – discuss with senior if unsure ☐
Persistent uncontrolled hypertension (BP $> 230/120$ mmHg) ☐	Acute bacterial endocarditis ☐
Thrombocytopenia ($<75 \times 10^9/l$) ☐	Surgery expected within the next 12 hours ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Trauma with high bleeding risk e.g. Head Injury ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	eGFR <30 ml/minute/1.73m ² : Dose reduction required ☐
	Heparin induced Thrombocytopenia ☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐

*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

(on day of surgery, at the later of either 4h post-op or 6pm)

Reduce Enoxaparin to 20mg if <50 Kg or eGFR <30 ml/minute/1.73m² ☐

If weight > 120 kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

- Peripheral neuropathy ☐
- Peripheral arterial disease ☐
- Cellulitis or Gross oedema ☐
- Leg deformity or Fragile skin ☐
- Leg / foot ulcers ☐
- Allergy ☐
- Unusual leg size/shape ☐

Risk assessment result – please tick $\checkmark$ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____

Signature: _____

Date: _____

Medicine Reconciliation Form

Source of information:

ECS Patient :

Relative/ 
carer

GP 
surg

GP computer printout/letter ☐

Patient's ☐
own drugs

Other
(specify)

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
Duloxetine	60mg	BD	O				✓	
Zopiclone	3.75mg	OD	O				✓	
Lactulose	15ml	BD	O				✓	
Paracetamol	1g	QDS	O				✓	
Ramipril	2.5mg	OD	O				✓	
Pregabalin	300mg	BD	O				✓	
Diazepam	5mg	OD	O				✓	
Senna	15mg	ON	O				✓	
Quinine sulfate	200mg	ON	O				✓	
Esomeprazole	40mg	BD	O				✓	
Tolterodine	2mg	BD	O				✓	
Allergies/adverse events				Penicillin				

List obtained by AR BK Designation C12

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Direct Admission

Consultant Review

WRIGHT

19/7/17

MON

44Q multiple comorbidities are fibromyalgia
chronic pancreatitis
chronic pain
TB shingles

Jan 2017 - headache - neck stiffness

- had LP

- states has had headache since

Attended ED & worsening of chronic
headache over 4/7

CTB - nil acute

NCC 10.8

nd 5.2

Pain is like needles in eyeballs

UTER

Very fatal

CRP 2

No vomiting

Noes & waves

Can mobilise to toilet

6 pt happy

Not had strong analgesic

= plan

Wanted more LP

No other issues

AA dec equal ale 11 + 11 + 0

6/5 15/15 No rashes

① eye movements NO weakness

No Neck stiffness

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CXR ☐
- EKG ☐
- Oxygen ☐

EDD

Imp / ① chronic migraine
Differential ② CF leak test LP

plan, ① allow neuro ② med rec.
② FGA
③ sumatriptan
④ analgesic

PRINT NAME

DESIGNATION

SIGNATURE

19/7/17 TIME

Clinical Notes

19/7/17 Fuz Brncl

DW neurology req → advises the following:

- Aspirin 900mg today & 10mg nelsolapranide
- Sumatriptan 50mg in initial headache
- Long term → paracetamol with analgesic initially
10mg route + titrated up by 10mg every 15 mins
q 6-7mg/day.

Advises post LP headache / CSF cells high
unlikely given history.

T2
Fuz

20/7/17 BMET WR//
SM7

headache completely resolved
→ share Rx advice from
neurology

bloods (N)
cCa²⁺ (N)

(N) CRP

CSF - nil repeated
last Feb 17: (N)

no new Sx
62 D ok

also (N) no T²T

→ check β-hCG **
allow (H) today
no new advice /
neurology recommended GP FU

BMET



0712726128

SULLIVAN

2 Deborah

07/12/197

6 Muirhead Court

Baillieston

Glasgow, Lanarkshire

G69 7E1

GLASGOW ROYAL
INFIRMARY

Patient Sample Report

Patient

ID: 0712726128
Last Name: SULLIVAN
First Name: DEBORAH
Gender/Age: Female, 44 years
Birth Date: 07.12.1972

Status: ACCEPTED

Analyzed: 19.07.2017 03:52:02

Sample Type: Venous

Sample Number:

Clinician:

Operator ID: GALVIN GANO

Analyzer

Model: GEM[®] Premier 4000
Area: GRISPAE
Name: GRI SPARE
S/N: 08061613

Measured (37.0°C)

CH	40.9	nmol/L
pCO ₂	5.6	kPa
pO ₂	7.0	kPa
Na ⁺	136	mmol/L
K ⁺	3.8	mmol/L
Cl ⁻	109	mmol/L
CO ₂	1.16	mmol/L
Glu	5.8	mmol/L
Lac	1.0	mmol/L

CO-Oximetry

tHb	132	g/L
O ₂ Hb	83.9	%
COHb	4.3	%
MetHb	0.8	%
HHb	10.9	%
sO ₂	88.5	%

Derived

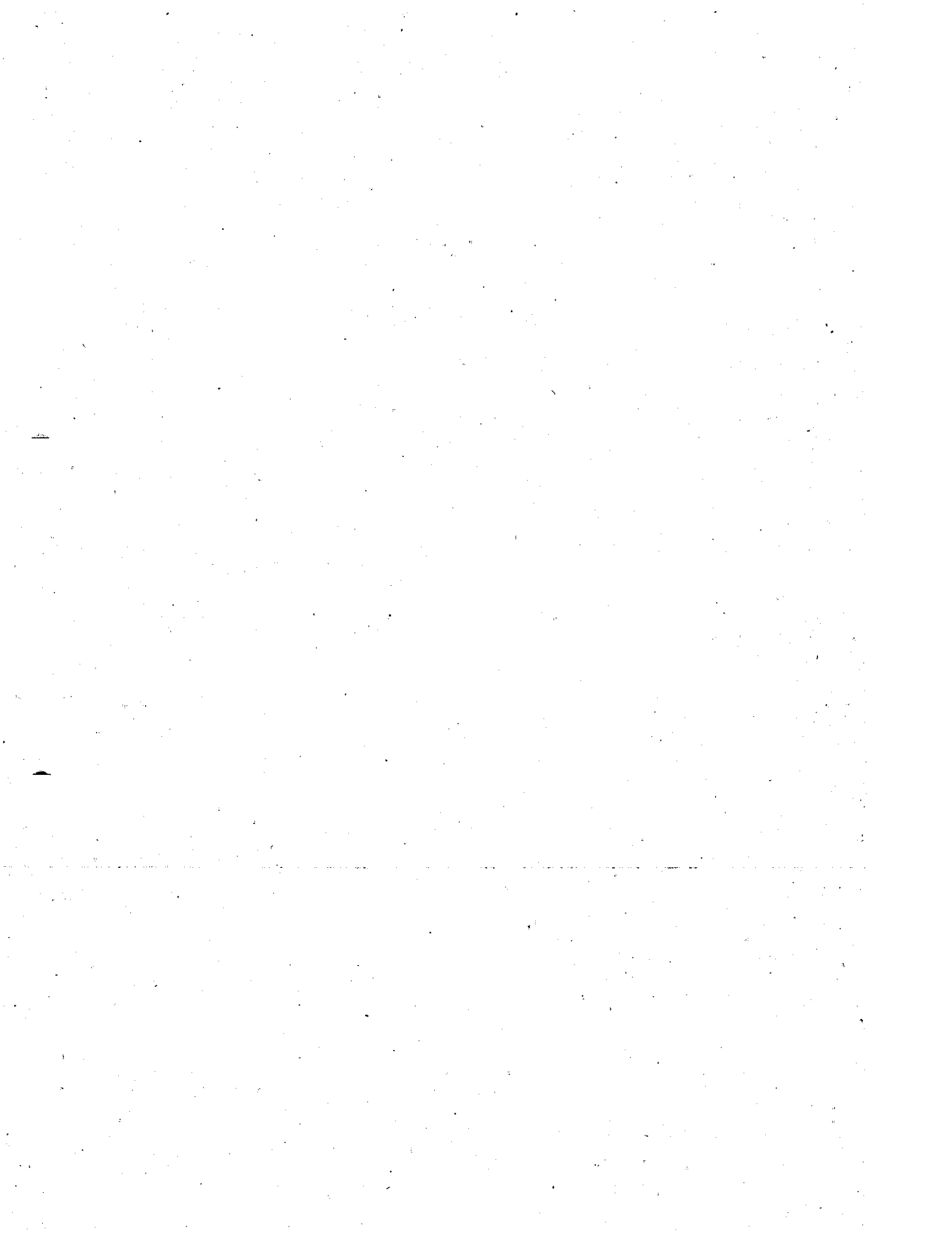
BE(B)	0.3	mmol/L
HCO ₃ ⁻ (c)	25.4	mmol/L
Hct(c)	40	%

Operator Entered

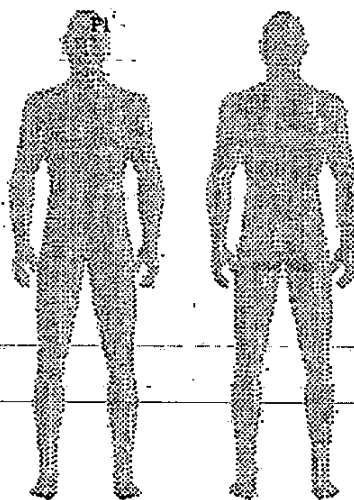
Temp 37.0 °C

O2 and Vent Settings

FIO₂ %



Scottish Ambulance Service Patient Report Form																			
Incident Number	CR003905036 on 18/07/2017 at 23:15																		
Call sign		Incident Type	EMG																
Crew1	E0019558	Crew3																	
Crew2	E0000076	Crew4																	
INCIDENT LOG																			
Incident Location	6 MUIRHEAD COURT BAILLIESTON GLASGOW		Incident Postcode	G69 7EP															
Call Received	23:15 - 18/07/2017		Patient at Hospital																
Call Passed	23:19 - 18/07/2017		Patient Handover																
Crew Mobile	23:19 - 18/07/2017		Crew Clear																
Crew at Scene	23:37 - 18/07/2017		Clear Reason																
Crew Left Scene	23:51 - 18/07/2017																		
Pre-alert Medical Standby																			
Receiving Hospital	GLASGOW ROYAL INFIRMARY																		
DIAGNOSIS																			
Chief Complaint Code	18																		
Despatch Code	18C05J : Headache with Numbness - Clear Evidence (Less than T hrs)																		
Diagnostic Code	18B01 : 18B01 - Headache/Unknown Status other codes N/A																		
PATIENT DETAILS																			
Surname	SULLIVAN																		
Forename	DEBORAH																		
Middle Initials		Sex	Female																
DoB	07/12/1972		Age	44y															
Patient Address			Patient Postcode																
Patient Telephone			Ethnicity																
PATIENT CONSENT																			
Mental Capacity Assessed	Deemed To Have Capacity																		
Level of Consent	Advice Given To Patient, Risks Of Condition Explained, Treatment Benefits Explained																		
PRIMARY SURVEY																			
AVPU Assessment	Alert																		
Catastrophic Haemorrhage	No																		
Airway Assessment	Clear																		
Breathing Rate	Normal																		
Respiratory Rate	18																		
Pulse	Fast																		
Most Peripheral Palpable Pulse Found	Radial																		
Skin Colour	Normal																		
Skin Texture	Dry																		
Circulatory Compromise	External																		
CSI Assessment	No Evidence Of C-Spine Injury																		
VITAL SIGNS																			
Time	Pulse	Rthm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	PS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
23:39	115	Reg	Alert	18	131	97		9.3	37.4	97		< 2 Secs	Sinus tachycardia	2	15	6.6	2		
23:49	111	Reg	Alert	18	143	99				98		< 2 Secs	Sinus tachycardia	1	15	7.8	2		
AMPLE																			
Allergy Type	PENICILLIN																		
Previous Medication	WITH PT																		
Previous Medical History	GALLSTONES, PANCREATITIS, FIBROMYALGIA, SHINGLES, HEADACHES																		
Last Eaten Before Incident	More Than 5 Hours																		
EYES AND PUPILS																			
Left Eye			Right Eye																
Left Pupil Size	Normal		Right Pupil Size	Normal															
Left Pupil Reaction	Normal		Right Pupil Reaction	Normal															
Unequal Reaction To Light																			



SEPSIS

Pulse	RR	SYS	Temp	GCS	BG	Pneumonia	UTI	Other infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound infection	Infected indwelling device	No signs of infection
115	18	131	37.4	15	9.3	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
111	18	143		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
23:39	Spontaneous	Orientated	Obeys Commands	15
23:49	Spontaneous	Orientated	Obeys Commands	15

PATIENT SUPPORT

Next of Kin	COURTNEY KELLY	Next of Kin Telephone	
Next of Kin Address			

ADDITIONAL COMMENTS AND OBSERVATIONS

999 FOR 44 YOF WITH SEVERE HEADACHE SINCE 11PM APPROX. O/A PT ALERT AND ORIENTATED. GCS 15. FAST NEGATIVE. PAIN IS SHARP AT THE FRONT OF HER HEAD AND BEHIND HER EYES. NO NAUSEA. PT HAS HAD EPISODES OF BLURRY VISION, LIGHT SENSITIVITY. DENYING ANY OTHER PAIN. NO NECK STIFFNESS. PINS AND NEEDLES IN LIMBS. PT BEING INVESTIGATED WITH HER HEADACHES, GP QUERYING MIGRANES. PT STATES THIS HAS BEEN MOST SEVERE HEADACHE SHES HAD.

REPORT MANAGEMENT

Report ID	CR003906036-18072017235801	Report Type	Interim
Software Version	1.0.444		



CHI: 0712726128

Glasgow Royal Infirmary

(12)

Total Att: 20

Title: MS

12 Mth Att: 1

SULLIVAN

Deborah

DOB: 07/12/1972

Age: 44y

Sex: Female

6 Muirhead Court
Baillieston
Glasgow
LanarkshireNext of kin: SULLIVAN, KATHLEEN
Relationship: Parent
771 3743

G69 7EP

GP: G MacAllister

0141 531 8050

Attendance Date: 12/01/2017

Arrival Time: 08:48

Registration Time: 08:48

Date of Incident: 12/01/2017

Major Incident Desc:

Reason for Attendance: abdo pain

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 12/01/2017 08:52

Nurse name: Nurse Nicole Pratt

Temp	35.5	C
HR	76	bpm
BP	145/73	mmHg
MAP	97.00	mmHg
RR	16	bpm
SpO2	98	%
Oxygen		%

BM	9.2	mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

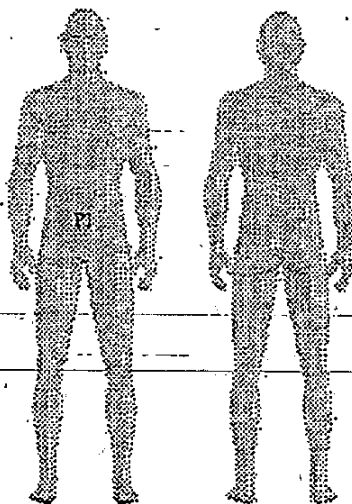
Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "central abdo pain and vomiting since last pm. known pancreatitis, colesystectomy, IBS. had own tramadol and paracetamol."

0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah0712726128
SULLIVAN
Deborah

0712726128

Scottish Ambulance Service Patient Report Form																			
Incident Number	CR003477926 on 12/01/2017 at 07:26																		
Call sign				Incident Type	EMG														
Crew1	E0031224			Crew3															
Crew2	E9888216			Crew4															
INCIDENT LOG																			
Incident Location	6 MUIRHEAD COURT BAILLIESTON GLASGOW			Incident Postcode	G69 7EP														
Call Received	07:26 - 12/01/2017			Patient at Hospital															
Call Passed	07:26 - 12/01/2017			Patient Handover															
Crew Mobile	07:27 - 12/01/2017			Crew Clear															
Crew at Scene	07:34 - 12/01/2017			Clear Reason															
Crew Left Scene	08:16 - 12/01/2017																		
Pre-alert Medical Standby																			
Receiving Hospital	GLASGOW ROYAL INFIRMARY																		
DIAGNOSIS																			
Chief Complaint Code	CSDY																		
Despatch Code	CSDY																		
Diagnostic Code	01A01 : 01A01 - Abdominal Pain																		
PATIENT DETAILS																			
Surname	Sullivan																		
Forename	Deborah																		
Middle Initials				Sex	Female														
DoB	07/12/1972			Age	44														
Patient Address	AS			Patient Postcode															
Patient Telephone				Ethnicity															
CHI Number	0712726128																		
PRIMARY SURVEY																			
AVPU Assessment	Alert																		
Catastrophic Haemorrhage	No																		
Airway Assessment	Clear																		
Breathing Rate	Normal																		
Respiratory Rate	16																		
Pulse	Fast																		
Most Peripheral Palpable Pulse Found	Radial																		
Skin Colour	Normal																		
Skin Texture	Dry																		
Capillary Refill Rate	< 2 Secs																		
CSI Assessment	No Evidence Of C-Spine Injury																		
VITAL SIGNS																			
Time	Pulse	Rhythm	AVPU	RR	SYS	DIA	PEF	BG	Temp	SpO2	FS	CRT	ECG	Sepsis	GCS	RTS	NEWS	ETCO2	Lactate
07:38	114	Reg	Alert	16	174	137		9.2	37.2	96	9	< 2 Secs	Normal sinus rhythm	2	15	6.6	2		
07:55	114	Reg	Alert	16	151	96				96	9	< 2 Secs		1	15	7.8	2		
08:10	99	Reg	Alert	16	145	96				100	6	< 2 Secs		1	15	7.8	1		
AMPLE																			
Allergy Type	PENICILLAN																		
Previous Medication	WITH PT																		
Previous Medical History	FIBRE MYRALGIA, IBS, APPENDIX REMOVED, GALL BLADER REMOVED, CONSTOPATION, CHRONIC PANCREATIS, DEPRESSION																		
Last Eaten Before Incident	More Than 5 Hours																		
Events Prior To Incident	0200 PT SUFFERING FROM CENTRAL ABDO PAIN																		
EYES AND PUPILS																			
Left Eye										Right Eye									
Left Pupil Size	Normal									Right Pupil Size									
Left Pupil Reaction	Normal									Right Pupil Reaction	Normal								
Unequal Reaction To Light																			
MEDICINES																			
Drug	Time	Dosage	Route	Crew No	Batch/Expiry	Pain Before	Pain After												
Entonox	08:01		Inh	E9888216		9	6												



SEPSIS

Pulse	RR	SYS	Temp	GCS	SG	Pneumonia	UTI	Other Infection	Abdo Pain	Diarrhoea	Abdo distension	Meningitis	Cellulitis	Septic arthritis	Wound Infection	Infected indwelling device	No signs of infection
114	16	174	37.2	15	9.2	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
114	16	151		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
99	16	145		15		NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO

GCS

Time	Eye Opening	Verbal Response	Motor Response	Total
07:38	Spontaneous	Orientated	Obeys Commands	15
07:55	Spontaneous	Orientated	Obeys Commands	15
08:10	Spontaneous	Orientated	Obeys Commands	15

PATIENT SUPPORT

Next of Kin	COURTENY KELLY	Next of Kin Telephone	
Next of Kin Address	AS ABOVE		
Accompanied by	DAUGHTER		

ADDITIONAL COMMENTS AND OBSERVATIONS

999 CALL TO 44 YO F ABDO PAIN, O/A PT LYING ON THE COUCH, O/E OBS AS ABOVE. PT COMPLAINING OF CENTRAL ABDO PAIN WORSENING ON TOUCH. PT SUFFERS FROM CHRONIC PANCREATIS AND PT FEELS THIS IS TH SAME PAIN. PT LEFT ARM IS LIKE A DEADWEIGHT AND LEFT LEG GIVING WAY. THIS IS AN ONGOING PROBLEM. PT HAD A BOWEL MOVEMENT THIS MORNING BUT WAS RUNNING. PT USUALLY CONSTIPATED AND TOLD CREW SHE HAS TO PUT FINGERS UP VAGINA TO HELP BOWEL MOVEMENTS. THIS MORNING SHE SAID SHE FELT HR COIL WHEN TRYING TO HAVE A BOWEL AND NOT SURE IF SHE HAS MOVED IT. TRANSF TO GRI

REPORT MANAGEMENT

Report ID	CR003477926-12012017083514		
Software Version	1.0.444	Report Type	Interim

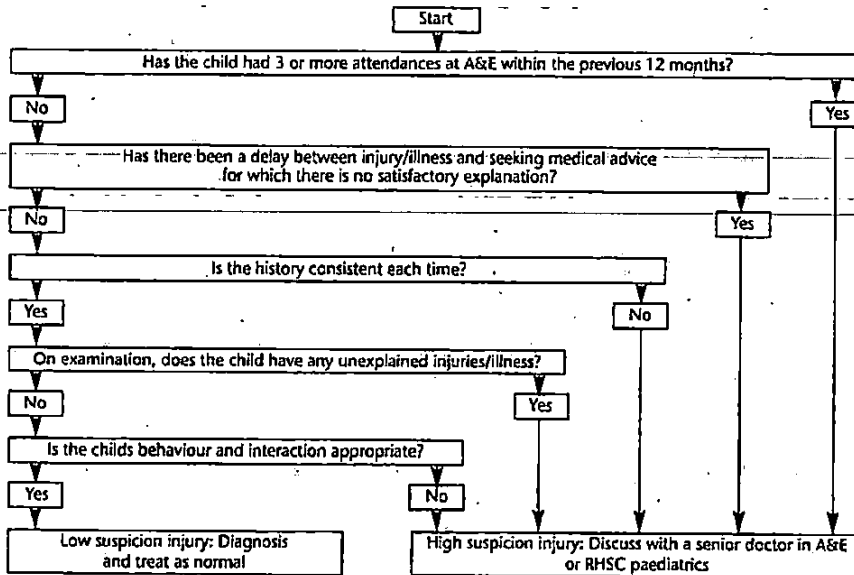
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)



0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
07/12/1972
G69 7EP

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I. Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

Date 2-1 Time 11:30 Name Mr HERN Grade Spec Specialty Spec

(PC) Abdominal pain

(HPC) Advice 130 AM @ epigastric pain radiating to back. Constant pain & sharp exacerbations. Vomited Good stuffs then brown fluid No more GE upset

Feels like previous biliary stones - pancreatitis

(Past) Gallstone pancreatitis - several episodes Cholecystectomy. Previous fundoplication

Please complete where appropriate:

AMT (if >65 years)

CURB Score (if <65 years)

SIRS

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Clinical Notes

Date Time Name Grade Speciality

Fibromyalgia. Appendicectomy

(PA) Pregabalin 300mg BD

Lactulose

Paracetamol 1000

Zopiclone 3.75

Tramadol 100

Fentanyl 75mcg patch (72hr)

DHC

Duloxetine 60mg BD

Glycine tabs

Follicle Zy B

Bonjorex 60mg

BD

NICDA

(SA) No alcohol

AE/

T35.5

RR 16

HR 76

Sats 98%

BP 145/73

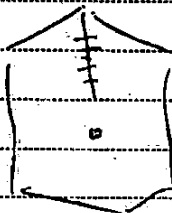
RS/LUS

Chest clear

HsIF II + 0

CRT C2

Abdomen



Soft BS ✓

Tender to epigastrium

Imp. Necrotic Pericarditis

? Dysphagia

→ IO access

IO Rx - Diclofenac / Morphine / Cyclob

Admit for obs as vomiting

Blacks etc → for PPI

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)



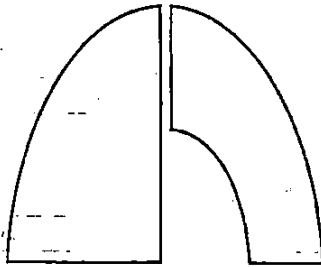
0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
07/12/1972
G69 7EP

Clinical Notes

[illegible]

* extensive
1. algebra

X-Ray results



0712728128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

F
07/12/1972

G69 7EP

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	Date and time
WCC	10.3
Hb	133
Plat	308
MCV	
Neut	4.7
DDim	Date and time
PT	(N)
PTT	
TT	

Bioch	Date and time
Na ⁺	140
K ⁺	4.7
Cl ⁻	109
Ur	3.1
Creat	68 24hr 760
Glu	5.2
CRP	4
Bil	Date and time
AST	21
ALT	4
GGT	
ALP	60
Prot	
Alb	37
Glob	
Ca ⁺⁺	
Amyl	Date and time
TSH	
FT4	
TropI	Date and time
Chol	
Trig	
Para	Date and time
Sal	
S osm	
ABG	Date and time
H ⁺	
PaCO ₂	
PaO ₂	
Bic	
BE	
FiO ₂	
Lactate	

ECG findings

Other investigations

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking away from)

the Hospital at my own desire
and contrary to the advice of medical staff.

I have had the risks of so doing explained to me, and accept full responsibility
for my action.

Signature

Witness Date

* Delete whichever is inapplicable.

Glasgow Royal Infirmary
Department of Surgery
(Part B - Surgical Admission)

NHS
Greater Glasgow
and Clyde

0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
07/12/1972
G69 7EP

Date & Time 12/1/17. Consultant G MACKAY Ward 67.

Ward Review 12:06 J. CONN CLIN. FOLLOW.

Check List

Bloods ☐

BHCG: +ve ☐ -ve ☐ N/A ☐

Urinalysis

ECG ☐

CxR ☐

AxR ☐

VTE prophylaxis ☐

Med Rec ☐

Kardex ☐

(44) - Epigastric pain

Bb:- Chronic pancreatitis

- Fundoplication 2004.

- Reversal e.e-do 2009.

- OGD (Miss Craig) Sept '15.

- Oesophageal spasm.

- Admitted to A on CP Nov '15.

- Cholecystectomy '96.

- ERCP - '96.

- Fibromyalgia,

HPL:- OGD Epigastric pain, radiate to back.

- Cramping pain. Similar to prev pancreatitis.

- Much better than this morning.

- Vomiting ~ 6x since pain onset.

- LBO - This AM - Constipated.

- Usually has to manually evacuate.

- Digital pressure in vagina helps.

- Urinary hesitancy, Polyuria Dysuria/Haematuria.

Drugs:- Tramadol, Ezonapride, Penthanyl patch (72°)

Pregabalin, Oxydrolone, Dinsopan (PRN)

Senna, Lactulose, Duloxetine, Cyclizine

- PENICILLIN allergy - Rash.

SHx:- Lives with daughter.

- Ex-Smoker early

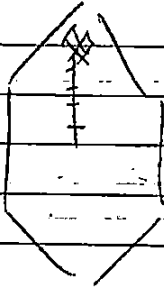
- Alcohol.

→

Ward Review

Patient Name
DoB
Unit Number
or affix label

O/E



- Epigastric tenderness
- Periumbilic tenderness
- Soft
- Distended

CRP = 4, WCC = 10.3
Amy = 66 U+E @

Imp :- Acute or Chronic Pancreatitis

- Plan :- Supportive Tx.
- Analgesics
 - F+D
 - Observe

[Signature]
ConW.

12/1/17, D-Conv.
16:12.

- ATSP due to photophobia
- Recent onset, never had before
- No headache
- No neck pain/stiffness
- ~~parasthesia~~ parasthesia in arms/legs
- Complained of weakness in @ arm + legs onset yesterday
- Dragging @ leg

O/E :- PEARL, Full ROM of neck & tenderness.

[Signature]

PRINT NAME

DESIGNATION

SIGNATURE

DATE & TIME

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]



- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.

Pt Addressograph

Operative patients

Non-operative patients

Is the patient bed-bound or expected to have reduced mobility relative to normal state for ≥ 2 days?

Yes ☐

No ☐

Does the patient have any risk factors for thrombosis? (tick $\checkmark$ all that apply)

Age >60 ☐	Use of oestrogen-containing contraceptive therapy ☐
Active cancer or cancer treatment ☐	Use of hormone replacement therapy or tamoxifen ☐
Dehydration ☐	Pregnancy or < 6 weeks post partum ☐
Known thrombophilias ☐	Critical care admission eg HDU/ITU ☐
Obesity (BMI >30) ☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis ☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease ☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease ☐
Personal history or first degree relative with a history of VTE ☐	Hip fracture ☐
Varicose veins with phlebitis ☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick $\checkmark$ all that apply)

Active bleeding ☐	Lumbar puncture, epidural/spinal anaesthesia
Acquired bleeding disorders (e.g. liver failure) ☐	• Expected within the next 12 hours
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis ☐	• Within the previous 4 hours ☐
Acute stroke (within 14 days) ☐	Other procedure with high bleeding risk - discuss with senior if unsure ☐
Persistent uncontrolled hypertension (BP $> 230/120$ mmHg) ☐	Acute bacterial endocarditis ☐
Thrombocytopenia ($<75 \times 10^9/l$) ☐	Surgery expected within the next 12 hours ☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands) ☐	Trauma with high bleeding risk e.g. Head Injury ☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery ☐	eGFR <30 ml/minute/1.73m ² : Dose reduction required ☐
	Heparin induced Thrombocytopenia ☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients - Enoxaparin 40mg + AES ☐

*prior to application of AES, please check contraindications to AES

Non-operative patients - Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50 Kg or eGFR <30 ml/minute/1.73m² ☐

If weight > 120 kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

- Peripheral neuropathy ☐
- Peripheral arterial disease ☐
- Cellulitis or Gross oedema ☐
- Leg deformity or Fragile skin ☐
- Leg / foot ulcers ☐
- Allergy ☐
- Unusual leg size/shape ☐

Risk assessment result - please tick $\checkmark$ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____

Signature: _____

Date: _____

Medicine Reconciliation Form

Source of information:

ECS ☒

Patient ☒

Relative/ ☐
carer

GP ☐
surg

GP computer ☐
printout/letter

Patient's ☐
own drugs

Other (specify) very sleepy

Patient Name

DoB

Unit Number

or affix label

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				Reason for alteration
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	
Prephalin	300mg	BD						
Lactulose	15ml	BD						
Diazepam	5mm	PRN						
Zopiclone	7.5mm	PRN						
Tramadol	100mg	QID						
Fentanyl patches	75mcg	72h						
Dihydrocodeine	30mg	PRN						
Paracetamol	1g	QID						
Duloxetine	60mg	BD						
Quinine Sulphate	200mg	PRN						
Senna	15mg	PRN						
Cyclizine	50mg	TID						PRN
Totterodine	2mg	BD				☒		Stopped pre-admission
Esomeprazole	20mm	PRN						
	40mm	BD						
Allergies/adverse events								
Penicillins => Rash.								

List obtained by

Rebbie Cor

Designation

Pharmacist #14004

Recently altered/discontinued medicines prior to admission and reasons why

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Very sleepy on RIV 13/1/17. - Rx'd PRN oramorph Regular 30mg DHC QID. Tramadol PRN -> Stopped while on oramorph. Review as pain settled.

Clinical Notes

Patient Name

DoB

Unit Number

or affix label

- Power sensation 5/5 in both (L) & (R) limbs.

Plan :- Observe.

- If gets any worse
? Medical r/v.
? CTB.

W.R. Stewart

12/1/17
1800

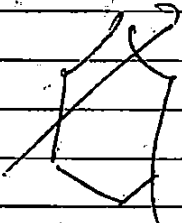
No objective evidence of chronic pancreatitis - previous CT - normal pancreas.

canv.

1728P.

Rash on abdomen - 2 shingles

PMH - GI motility disorder; Abonyelgia
Angiase (B)



SMT.

Imp. ? chronic abdo pain

Plan + E + D

- Analgesic
- Observe.
- Isolation for shingles
- Den Rerel

Plan
Rash on abd

13/1/17
0720

CT2 Montgomery
ATSP fall

PMI.

(L) leg gave way reports 27° of weakness of (L) arm + (L) leg - shingles rash headache + photophobia.

reflexes intact. (L) arm/leg 4/5 (R) 5/5
↓ ↓ plantar. sensation intact. (N) tone.

(L) homonymous hemianopia. Cerebral nerve otherwise (N) (N) pupils also

small bump to (L) parietal for fall BM 5.8

> 4hr hx :- not for thrombolysis

DW med reg lan - agrees.

(P) CT scan - DW radiology. They will carry out stroke team etc.

KLM

Clinical Notes

Patient Name

DoB

Unit Number

or affix label

13/1/17 W/R G McKay

Chronic pancreatitis, awake 0200 epigastric pain to back

L) sided weakness, headache & visual

defect overnight, photophobic, shingles rash

① CT head ± lumbar puncture

Medical R/V

Not for anti-virals at present - await scan results

AD

BUCKLE

GPST 1.1

BLG:- GS pancreatitis, cholecystectomy, last episode pancreatitis 2y ago

13/01

4 BUCKLE

15:30 CT - verbal report - no acute / no ev of stroke

Olw. MEd reg on call

Someone will come to review

13428

W/R McKay

13/01 NO Surgical issue at present.

1500 Normal CT scan.

The surgical team would like medical team to take over the care and perform ongoing appropriate investigations/treatment.

Thank you. As there is no ongoing surgical concerns.

Thank you.

KAR

KAR JMW VP 17/1

on behalf of Mr McKay.

13/1/17

McComney ST5 - Medicine

1800

4440 q. epigastric pain

headache / photophobia / intermittent neurological symptoms

?shingles

-presented with epigastric pain / vomiting → no surgical issue

-prior to admission → several days of frontal headache / photophobia

Clinical Notes

Patient Name

DoB

Unit Number

or affix label

generally unwell / her + cold. Has felt "not right"
for 13/52.

- Over the last 24h. → nr due to (L) upper +
lower limb weakness, leg "giving way",
hemiparesis-hemianopia on examination

- has rash in dermatomal distribution → pre-eruptive; painful.
- no episodes of confusion

Now → alert, oriented. Apyrexial although temp 39.4°C
previously.

Dermatomal rash. Not yet vesicles. ° meningism

° CN deficit

Patellar tone / reflexes ⊕

Reflexes ↓↓

Bloods: cell 9, neutrophils 4.2

CT head - no significant
abnormality

① Symptoms may be 2° pre-eruptive MZ viral infection.
Can occasionally cause encephalitis.

Inflam markers ⊕ and not confused, but has had ↑ temp
since admission.
Could be migraine with neurological component.

② Lumber puncture

- Analgesic

- If no surgical issue → medicine side team.

Lumber puncture. Verbal consent:

Sitting up. Aseptic. 8ml 1% lignocaine.

2nd pass → initially slightly blood-stained then
clear CSF

→ samples sent for biochem / micro / virology.

Post LP advice given. No complications /
complicable throughout

2050 WCC < 6 No bacterial seen
RCC 6

Clinical Notes

14.1.17 152 new admission

142 initiated

R/Ved by medicine yesterday

Patient Name

DoB

Unit Number

or affix label

Clearly documented medics will kindly accept Mrs Sullivan if no further surgical issues.

Request secondary c/v - if no medical issues Mrs Sullivan is fit for (H) from a surgical perspective.

Plan

- ① Contact medics
- ② ? (H)

[Signature]
JCB

F41

ID 14610

14/1/17 McConney STS Medicine

1300 - JMB

- Biochem from LP @. Should still wait for virology
- Micro - ve.

Headache (bare eyes persists but otherwise well)

① JMB Mckinnon

- Draft virology
- I have informed bed manager.

14/1/17 14:15 Karen Leslie FY1

Asked to chase virology: virology lab closed over weekend. Please could Monday day tell virology to chase LP result. Thanks

KL FY1

ID 11224

25783

Acute Services Division

Nursing Admission & Assessment

1. Admission



Hospital: <u>GRI</u>	Ward: <u>67</u>
Date of admission: <u>12/11/17</u>	Time: <u>14.00</u>
Admitting Consultant: <u>Mr. P. P. P. P. P.</u>	Admitting Nurse: <u>LCARWICH</u>
Expected date of discharge: <u>19/1/17</u>	

Name:	
Addr:	0712726128 SULLIVAN Deborah 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP
DoB:	07/12/1972

1. Patient Details

Preferred name: <u>Debbie</u>	Next of Kin (NoK): <u>Courtney Kelly</u>
Age: <u>44</u>	Relationship: <u>Daughter</u>
Religion: <u>Catholic</u>	NoK Address: <u>Same</u>
Telephone: <u>07713178392</u>	NoK Telephone: <u>07568098011</u>
GP:	NoK Aware of admission: ☒ Yes ☐ No
GP address: Dr. G MacAllister Moglane Practice Baillieston Health Centre 20 Muirside Road Baillieston Glasgow G69 7AD	Consent for information to be given to relative/carer/friend: ☒ Yes ☐ No Nominated relative/carer/friend contact:
GP telephone:	Telephone - Day: Telephone - Evening:

Is the patient a carer? ☐ Yes ☒ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☒ N/A

a. If 'Yes' please provide - Name: Relationship:

Contact telephone number:

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No

If 'Yes' obtain a copy and file with patient notes.

If 'No' to 'b' please inform medical staff. Name of doctor informed:

2. Presenting Complaint / Diagnosis

Have treatment / investigations:
Epigastric pain, Shingles
13/11 head CT @
Why does the patient think they are in hospital? Use patients own words: Pancreas, Pain, Sickness lumbar puncture

3. Allergies (including food allergies)

No known allergies: ☐ Penicillin allergy -> Rash

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO ₂	Temp
<u>S</u>	<u>4° PUNE</u>	<u>0</u>	<u>80</u>	<u>125/72</u>	<u>16</u>	<u>98</u>	<u>36.4</u>
Urinalysis: ☒ Blood, SG (Not sent)			BM	NEWS Score	Weight Patient reported for weight / Actual	Height Patients reported height / Actual	BMI
			<u>9.2</u>	<u>0</u>	<u>91.15</u>	<u>172</u>	<u>30</u>

5. Current Medication

Tramadol, Ezomeprazole, phentany,
pregabalin, Dihydrocodeine, Diazepam.
Senna, lactulose, Duloxetine, cyclizine

6. Relevant Past Medical History

Esophageal Spasm, fibromyalgia
Chronic pancreatitis ERCP
OGD - Sept 15
fundoplication. 2004
cholecystectomy.

7. Risk Assessment

MUST Screening Tool

- Is the patient's BMI:
 - > 20Score 0
 - 18.5-20Score 1
 - <18.5Score 2
 Score
- Has the patient had unplanned weight loss in the past 3-6 months?
 - < 5%Score 0
 - 5-10%Score 1
 - >10%Score 2
 Score
- If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
 - Score = 2
 - Not applicable: Score = 0
 Score

MUST Score:

If score 1 or more, complete full Nutrition Profile Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☒ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☒ No

Name:

Address:

DoB:

CHI number:

Affix patient data label

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☒ Yes ☐ No If 'Yes' complete the following section.

- Has the patient ever had a previous positive MRSA result? ☐ Yes ☒ No ☐ Not known
- Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☒ No ☐ Not known
- Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☒ No ☐ Not known

If 'Yes' to any of the above questions OR if the patient is admitted to a 'high impact speciality' e.g.

Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:

☐ Nasal ☐ Perineum ☐ Other - Specify: ☐ Patient refused

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☒ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☒ No If 'Yes' obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

lifestyle

Smoking:

Are you a smoker ☐ ex-smoker ☒ never smoked ☐

If ex-smoker when did they stop?1 month....

If smoker how many cigarettes per day.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☒ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

☒ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

☒ Never ☐ Less than monthly
☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Admission Documentation Completed By

Name (Please PRINT): LCARMICHAEL

Signature: *Leanne*

Designation: S/N

Date: 12-1-17

Nursing Admission & Assessment

2. Assessment

Name:	0712726128		
Address:	SULLIVAN	F:	
	Deborah	07/12/1972	
	6 Muirhead Court		
DoB:	Baillieston		
	Glasgow, Lanarkshire		
CHI r		G69 7EP	

Hospital:	GRI	Ward:	67
Date of Assessment:	12/1/17	Time:	14:00

1. Breathing and Circulation

Breathing:

- ☒ No symptoms or history of respiratory problems
 ☐ Productive / non-productive cough evident
☐ Dyspnoeic at rest
 ☐ Normally receives oxygen therapy
☐ Dyspnoeic on minimal exertion
 ☐ If 'Yes' provide details:
☐ Dyspnoeic on maximum exertion

Circulation:

- ☒ No symptoms
☐ known high blood pressure
 ☐ known angina
 ☐ current chest pain

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

RL

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required ☐ Not required ☒

If required, provide details and arrangement made:

Does the patient have:

- a. Speech difficulties? ☐ Yes ☒ No
 b. A learning disability e.g. Down's Syndrome?
☐ Yes ☒ No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:

☐ Yes ☒ No

c. A learning difficulty e.g. dyslexia, dyspraxia?

☐ Yes ☒ No

If 'Yes' please specify:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

RL

3. Senses

Senses:

Eyesight

- ☐ Normal vision
☒ Glasses - ☐ Distance ☒ Reading
☐ Prosthesis - ☐ Left ☐ Right
☐ Contact lenses
☐ Registered blind

Hearing

- ☒ Normal
☐ Hearing impaired
☐ Hearing aid - ☐ Left ☐ Right

4. Cognitive Status

Cognitive Status:

- ☒ Orientated
☐ Confused
☐ Distressed
☐ Aggressive / Abusive
☐ Known dementia
☐ Unconscious

5. Hydration and Nutrition

MUST Score: 0 If score is 1 or more, complete a Nutrition Profile.

Nutrition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / /

5a 1. Food likes / dislikes:

Soft Diet

5c. Help needed with eating and drinking:

☐ Yes ☒ No

If 'Yes' provide details:

5a 2. Fluid likes / dislikes:

Tea

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):

☐ Yes ☒ No

If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?

☐ Yes ☒ No

If 'Yes' specify texture: A ☐ B ☐ C ☐ D ☐ E ☐

Thickened Fluids required? ☐ Yes ☐ No

If 'Yes' specify stage required: 1 ☐ 2 ☐ 3 ☐

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

LE

6. Elimination

Continent:

☒ Bladder
☒ Bowel

Incontinent:

☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:

☐ Required ☒ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No

If Yes is it urethral ☐ suprapubic ☐

If 'Yes' - Size: fg Make:

Date catheter last changed: / /

Continence assessment commenced:

☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☒ Bowels regular

HAS IBS

☐ Constipated

☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☒ No

If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

LE

7. Personal Hygiene, Oral Health and Skin Assessment

Name: 
 Address: 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 6 Muirhead Court
 DoB: Baillieston
 CHI nur Glasgow, Lanarkshire G69 7EP

Personal hygiene:

- ☐ Self-caring and independent
☒ Requires assistanceX.1

Specify assistance if required:

Wash & Dress

Oral health:

- Self-caring and independent ☒ Yes ☐ No
 Does the patient have a sore mouth ☒ Yes ☐ No

- Does the patient have a non healing mouth ulcer ☒ Yes ☐ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway). attends dentist.

Dentures:

Does the patient wear a denture plate?

- ☐ Yes ☒ No

If yes complete the following:

- ☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

- ☒ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☒ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet - Grade:

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

LR

8. Mobility

Patient fully mobile / independent? ☒ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☐ Mobile with aid - Specify:

☐ Prosthesis - Specify:

Moving and Handling Plan commenced:

- ☐ Yes ☒ No

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

LR

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☒ Yes ☐ No

If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details: analgesia

Bed rail assessment completed: ☒ Yes ☐ No

Bed rails required:

- ☐ Required ☒ Not required

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

LR

0. Sleep and Rest

Sleep habits:

- ☐ Less than 8 hours
 ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

- ☐ None
 ☒ Disturbed
☐ Early waking
 ☐ e.g. nocturia, insomnia

Medication required: ☐ Yes ☒ No

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

R

1. Social Circumstances

- ☐ Employed ☒ Unemployed ☐ Retired
☐ Health problems at work
☐ Lives alone
☒ Lives with Family Daughter
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services

Unpaid carer ☒ Yes ☐ No

If Yes are they Partner / Friend / Son / Daughter

What kind of care do they provide?:

- ☐ Private Carers
☐ None

If support services in place, please provide details:

Daughter helps wash, dress shopping. House work.

Does the patient have any money worries? ☐ Yes ☒ No

If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?

☐ Yes ☒ No

If Yes please identify date patient referred:/...../.....

Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering

☐ Yes ☒ No

If Yes please identify date patient referred:/...../.....

Problem identified: ☐ Yes ☒ No If 'Yes' please describe

Initial

LE

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☒ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☒ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☒ No

If 'Yes' please provide brief details:

Ask the patient:

"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☒ Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☒

Is the patient aware of their:

Diagnosis? ☐ Yes ☐ No

Prognosis? ☐ Yes ☐ No

Is the patient's family aware of their:

Diagnosis? ☒ Yes ☐ No

Prognosis? ☐ Yes ☐ No

Preferred place of care:

Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:

Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No

If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

Name: 0712726128
Address: SULLIVAN Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
DoB: 07/12/1972
CHI n: G69 7EP

15. Admission Assessment Completed By

Name (Please PRINT):

LCARMICHAEL

Signature:

[Signature]

Designation:

S/N

Date:

12-1-17

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
12-1-17 14.00	patient admitted to ward 67 following an episode of Epigastric pain, patient suffers from chronic pancreatitis. Pt states it began last night she had (L) sided weakness & sensitivity to light, but her epigastric pain was her main concern. patient allowed F+D	

Nan	0712726128	
Add	SULLIVAN	F
	Deborah	07/12/1972
	6 Muirhead Court	
DoB	Baillieston	
	Glasgow, Lanarkshire	
CHI	G69 7EP	

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
14:30	analgesia & observe.	SM Loan
	observations charted news o	
	urine obtained blood & SG	
14:30	not sent.	Loan
	ur. Brian Stewart :? shingles	
	Allow fluid and diet.	
	Analgesia	Lynne Murray D. Sullivan
23:50	FT 39 4 FT 39 4 FT 39 4	
	182	
03:25	Patient uncomfortable	
	throughout the night,	
	tramadol given. Medication	
	as per kordex. News of	
	a + cloraxing F + P.	
	Passing urine about 17N	
	am.	am D. Sullivan

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

0712726128

SULLIVAN

Deborah

6 Muirhead Court

Baillieston

Glasgow, Lanarkshire

F
07/12/1977

G69 7EP

Please tick ☒ appropriate directorate

Date & Time	Signature, Print Name & Designation
15/11/17	MR McPherson
	Obs stable.
	Anxiety medical take done.
	KL FY1
15.1.17	R/U - FALL
	ATSP by nurse due to patient being found on the floor in the bathroom.
	Pt recalls the incident and described standing from the toilet and feeling her (L) leg give way from underneath her.
	claims to have
	Pt hit her head on falling but expresses no headache, dizziness
	° LOC
	° no new neurological deficit
	° no incontinence
	° headache
	° vomiting or nausea
	° dizziness
	° seizure activity
	° rhinorrhoea, otorrhoea
	Pt informs me she has PMH of fibromyalgia which she believes have been contributing to episodes of

Date & Time		Signature, Print Name & Designation
	① sided weakness as for back as 4 months	
	Previous episodes have been	
	noted and medical rx also	
	noted.	
	Furthermore pt reported no	
	visual disturbances; no speech	
	abnormalities and no no	
	no new focal neurology.	
	PT orientated to space and	
	time; obs stable.	
O/E	CN I - no change to smell	
	CN II - visual acuity intact	
	- fields not examined	
	(homonymous hemianopia	
	not on previous exam)	
	- accommodation intact;	
	along with direct and	
	consensual pupillary constriction	
	CN III, - int findings	
	IV, VI	
	CN V - sensory and motor function	
	intact	
	CN VII - motor function intact	
	CN VIII - not examined	
	CN IX, - intact, no tongue	
	X deviation.	
	PTO	

CLINICAL NOTES - MEDICAL ☒
NURSING ☐Please tick ☒ appropriate directorate

0712726128

SULLIVAN

Deborah

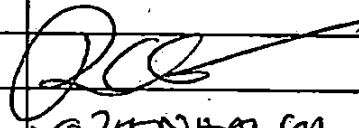
6 Muirhead Court

Baillieston

Glasgow, Lanarkshire

07/12/1972

G69 7EP

Date & Time	Signature, Print Name & Designation
R/V fall - cont	
Marked weakness of (L) upper + lower limbs with sensation, tone normal. findings of sensation, tone, proprioception and vibration in all 4 limbs.	
Imp ? cause of stroke (L) sided hemiparesis.	
Med's happy the cause is not vascular. Awaiting LP results.	
Plan	
1. Have instructed pt to inform nurses if she wants to mobilize	
2. Requested standing BPP.	
3. Continued observations	
4. Chase LP	
	 GRENTHAM RM F14610

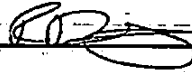
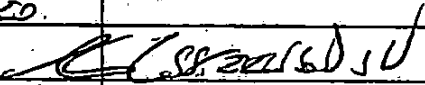
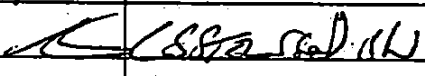
Date & Time		Signature, Print Name & Designation
16/1/17	Mr Mackay	
10:55	Entries over weekend noted.	
	- Reviewed fall story	
	- Encouraged to tell nurses when mobilising	
	- Patient continues to await medical bed.	
	Plan: Chase medical bed with bed manager	
		T. McIn
17/1/17	Mr Ross	
08:40	NEWS 0	
	Ing markers NAD	
	Plan: Chase urology	
	Chase medical bed	
		T. McIn
		R. Nelson
17.1.17	Seen by Falls Coordinator, please	
11:30	See attached notes in nursing notes.	
		Steve Storer Ext 2558
17/1	FI BAKTAM.	
12:50		
	Pt complaining of ① sided facial pain.	
	Shooting pain up face, now stopped.	
	Also complaining of ① sided tenderness.	No acute changes in vision
	0/4 - obs stable	scalp tenderness
	(cranial nerves ②) (acuity not evaluated)	
	Generalised tenderness to touch along whole ① side.	
	No skin changes P/Dlw medics	
	Imp 1 ? dental pain ? touch on nt	BSF #13428



Date & Time		Signature, Print Name & Designation
19/01/17	Nursing notes - NIGHT.	
22 ⁰⁰	Pt admitted to rd 20/21 via rd 67. Transferred independently into bed. Orientated to rd, staff & Nurse buzzer. Fentanyl patch 75mg & PRN Analgesia administered as required. Settled on admission.	Shw [Signature] Smith
20/01/17	Settled & slept well. 0500 Vital signs stable - Apyrexial. Medication given as per Kardex Independent to the toilet - No issues mentioned. Nil complaints at time of writing.	Shw [Signature] Smith

CLINICAL NOTES - MEDICAL ☐
NURSING ☒0712726128
SULLIVAN
DeborahF
07/12/1972Please tick ☒ appropriate directorate

Date & Time		Signature, Print Name & Designation
06/06	Patient complaining of dead weight on L Flank Side. Patient able to move both limbs observe.	Eden
	Medical Staff aware.	
07/06	Patient fell on floor when getting up to toilet. News - OGS 15 advised to use nurse call buzzer when requiring assistance. Medical Staff r/v Patient complaining of weakness L side. CT head today. Patient has noticeable bump on head. BM 5.8.	Eden SN
	Falls Risk assessment been updated. Patix been completed, Ref - 391965.	E. P. SN
11/06	For head CT and medic /stroke r/v.	Abel ABEL SN.
11/45	Does not wish a wash this morning. Not keen on diet. Tolerating oral fluids. Observations stable. Anticipating head CT.	Abel ABEL SN
	Head CT Normal.	
	- patient dysphagic with solids post water swallow test	

Date & Time		Signature, Print Name & Designation
	Lumbar puncture carried out for medical bed.	
	G&F sent for biochem/micro/virology	
	no further concern	 SN.
02:00	Patient Settled and slept well. No complaints of Pain. News of I.P 91, GCS Stable. Patient walking to toilet. - advised to use nurse call Buzzer at all times when mobilising. Medical Reg stated No acute issues still awaiting results from Lab. Patient awaiting medical Bed. States Struggles to Swallow. Reassess tomorrow. Patient has ongoing problem for years. Drinking oral fluids. Passing urine.	
08:30	S/B Mr. McManus advised No surgical issue. Discuss with MEDICAL RT to NEW BUNDOCK RD. NO DISCHARGE Home	
16:00	WOUND INSPECTION. Fwised D/B. Rechecked. Nurse noted wound area. S/B medical contacts of oral. Kidney/80mg. Olanzapine. As per KNEED. Alert 1	
15:11	Oramorph required for pain.	
03:30		

CLINICAL NOTES - MEDICAL
NURSING
☐
☒
Deborah
SullivanPlease tick ☒ appropriate directorate

Date & Time		Signature, Print Name & Designation
15/11	mobile around ward	
	all meds as prescribed.	
	Obs stable	SW Lohan
0900	S/B McNamee still to S/B physical	
	Today - no change in status video	
	Relief from lower back	
1100	Washed in shower. Eased right	
	Tolazone. Has voided urine	
	Fully mobile NEWS 1100. Worry	
	the nurse (Pamela Brown)	Deborah Sullivan
1740	Deborah was found	
	on the Bathroom floor	
	in Room 7 at 17.45.	
	Observations taken now	
	of ¹⁴⁵ NEWS OBS 15/15	
	Obs informed who	
	examined patient.	Dines
	BATIX completed. Patient	Dines SN
	complaining of leg	
	weakness and has small	Dines
	swell above right eye.	Dines SN
	for Lying/sitting BP	
	+ escort to toilet.	
	Cancelled updates	
NIS	NEWS 0.	
	Oramorph given as	
	prescribed for pain relief	
	oral meds as charted.	
	Advised to get help	

Date & Time		Signature, Print Name & Designation
17/11	when walking to toilet.	
	clo pain FUI informed.	
0130	Oramorph increased to	
	2mg with poor effect	
	Wishing to speak to	
	SHO. Reviewed	
	very anxious diazepam	
	Saps given as charted.	
	DF118 dose to be	
	reviewed. for pain	(G. Mervin)
	review as inpatient.	Chelapa (G)
NIR	For urgent transfer to medicine.	
	medical bed at the manager.	
	aware.	(J. All ABEN SN)
	fully independent with personal care.	
	Recommended to use nurse call	
	system. However patient leaving ward	
	for a cigarette against advise.	
	Oramorph given. Observations stable.	
	falls map initiated. Asking to hear	
	whether a bed is available.	(J. All ABEN SN)
	faces MAP 7am in situ	also Dimes on
N/S	Settled night. Mood bright	
	news 0.	
	Oramorph given as prescribed	
	for pain relief.	
	Pentynal Patch 75mg	
	renewed as charted.	
17/11/17	Slept well overnight.	
	20 active care carried out.	(G. Mervin)
	For medical bed.	Chelapa (G)

CLINICAL NOTES - MEDICAL ☐
NURSING ☒Dewan
Sullivan
0712726128Please tick ☒ appropriate directorate

Date & Time		Signature, Print Name & Designation
17/1/17	Independent with personal care	
19 ⁰⁰	Came eat + drink. Voiding urine.	
	Encouraged to use buzzer for assistance when she needs to mobilise.	
	Observations: deficient between	
	Lying + standing noted. MI informed	
	of severe @ sided facial pain.	
	Oramorphone given. MI contacted	
	medico who will RV patient today.	
	? neuro RV. sps fall team. see attached	
	notes. ? for priority transfer to a	
	medical bed once named consultant	
	is known.	Stella Housh
18/1/17	Independent with ADL	
09 ⁰⁰	Voiding F+D.	
	Voiding urine spontaneously	
	Medication as charted.	
	Observations within normal	
	limits.	
	Pain as prescribed with good	
	effect.	
	Awaiting bed in medicined.	
	Awaiting neurological RV	
	Settled night	Burdon
	Slept at time.	MAHO
09 ⁰⁰	Pain score 9/10 oral paracetamol	
	Dihydrocodeine given, continue	Burdon
	to monitor	MAHO

Date & Time		Signature, Print Name & Designation
18/1/14 WIC 0915	SIB MED STIC TO SIB MEDICAL STAFF FOR MEDICAL BED WHEN AVAILABLE REFERRED TO TARGET TEAM REQUEST BUILD + MOBILISE / ENROUTE INPATIENT AND MOBILISE. WANTED WITH MEDICAL STAFF FOLLOWED BY TELEPHONED ENROUTE TO MOBILISE. SURGES ATTEMPT TO RE-DO ? REQUEST SIDE ROOM. NEWS = 0. ANALGESIA AS REQUESTED (SIB MED STIC)	
1800	NO SURGES IN MEDICAL ANALGESIA AS REQUESTED (SIB MED STIC)	
19/1/14 0125	Independent with Personal Care Patient caused to use nurse call system, for nurse to assist / supervise mobilising round bed area. Voiding urine spontaneously Pulse 91, News 1, Asymptomatic Pain has been issues with pain throughout the night. Oromorph given with good effect Night sedation as charted with good effect, slept at times overnight Awaiting bed medication Slept for spells overnight	
0410 0900 Rush AN	R/V by ward pharmacist, now booked AS REGULAR TRAPDOOR. FOR ACHOLYCE X 5 DAILY SEE KNOWN	(SIB MED STIC) Bridson Bridson Bridson



-07/12/1972

Please tick ☒ appropriate directorate

Date & Time		Signature, Print Name & Designation
1500	WASSED INDEPENDENTLY. FUSION DIED AS TOXICATED. HAS VOICES WHEN MOBILIZED BY PUFFING TALKERS. Observed recently SEE KNOX NEWS 1 P92. FOR TALKER TO WD2/13	E Skarsen
20/1/77	NR.	
1210	Renewed Day 9 admission chronic abdo pain & HZV T8 L Dermahome -ve CSF / CTB Day 7 acidosis. Home today Stop DHS as per Pharmacy advice +O musas +EX CON 07881815828.	Dermahome
20/1/77	Nervous Day seen by consultant Rome today.	G. JALUKAN

In-patient Post Fall Multidisciplinary Review

Following an in-patient fall, a 3 part multidisciplinary review must be undertaken.

- Section 1 to be completed by a registered nurse.
- Section 2 to be completed by a Junior doctor or HAN.
- Section 3 to be completed by a senior doctor and SCN to review the care delivered.

An action plan must be developed, implemented and reviewed. Learning from the review must be shared within the multidisciplinary team.

Following the incident, and the completion of this form, details must be entered into Datix by the nurse who first discovered the fall.

Section 1 - Nursing Review

SECTION 1 - TO BE COMPLETED IMMEDIATELY POST FALL BY A REGISTERED NURSE			
PATIENT NAME:  CHI: 0712726128 SULLIVAN Deborah F 07/12/1972		HOSPITAL: GR1 WARD / AREA: 65 DATE OF FALL: 13/1/17 TIME OF FALL:	
		Exact location of fall: RM 7 Was the fall witnessed by staff? YES ☐ NO ☒	
		What was patient doing at time of fall? If fall was un-witnessed, ask patient. Going to the toilet.	
REVIEW OF CARE POST FALL		REVIEW OF CARE	
Was the patient's buzzer at hand?	YES ☒ NO ☐ NA ☐	Result and date of last 4AT	= on / /
Had patient pressed buzzer?	YES ☐ NO ☒ NA ☐	Result of post fall 4AT	= on / /
Chair and bed alarm switched on?	YES ☐ NO ☐ NA ☒	Date bowels last moved	/ /
Previous Fall?	YES ☐ NO ☒ NA ☐	Post Falls NEWS	= 0.
If yes, how many?	YES ☐ NO ☒ NA ☐	Any signs of infection?	☐ Yes ☒ No
Known to Hospital Falls Coordinator?	YES ☐ NO ☒ NA ☐	If yes, detail where	
Did the patient have urine retention?	YES ☐ NO ☒ NA ☐		
Did the patient have walking difficulties prior to the fall?	YES ☐ NO ☒ NA ☐		
Pre fall frequency of active care prescribing BA hrs		Post fall frequency of active care prescribing 3 hrs	

Nursing Action Plan - detail action/s for future prevention and how this learning will be shared.	
Provide details of any other relevant information relating to the fall here: New onset of left sided weakness.	
IMMEDIATE ACTIONS TO PREVENT FURTHER FALLS:	Person Responsible:
1. To use buzzer & ^{not to} patient mobile on her own	S/N.
2. head CT, GCS. obs	
3. medical riv.	

Review of care completed by:		
Name: A Bell	Designation: Staff nurse	Date: 13/1/17

Date reported in Datix: 13/1/17	Datix reference number: 391965	Rapid Alert Reporting Process Actioned? ☐ Yes ☐ No ☒ N/A
---	--	---

Section 2 - Medical Review

Following an in-patient fall, this review must be completed by a ward doctor/HAN in charge of the patient's care. On completion of the medical review hand this form back to nursing staff for Datix reporting. File original copy into patient notes.

Section 2 - Medical review immediately post fall by ward doctor – examine patient in bed				
ANY SIGN OF INJURY?	No (tick)	Yes (tick)	Actions:	Yes (tick)
1. Head injury?			Neuro Obs (instruct nurses)	
- Neurological examination normal?			CT head	
- GCS = E			Other (describe):	
M				
V				
2. Possible fracture? (examine in bed)			Xray of (state site) :	
- Painful limb / joint?			- Urgently (discuss with senior if in doubt)	
- Tenderness / deformity any area?			- Non-urgently, next day	
- Shortening / external rotation of a leg?			Other (describe):	
- Change in mobility / function?				
3. Soft tissue injury?			Suturing of wound	
- Cut / abrasion?			Immobilisation of limb / joint	
- Bruising / sprain?			Other? (describe):	
- Other? (describe):				
WHY DID THE PATIENT FALL?	No (tick)	Yes (tick)	Actions:	Yes (tick)
- Impaired balance? (eg. cerebrovascular disease, musculoskeletal disorder, neuropathy, movement disorder)			Consider further examination & investigations (discuss with senior if in doubt)	
- Syncope? (eg. postural hypotension, arrhythmia, aortic stenosis)			Auscultate heart, Lying/standing BP, Consider ECG and echo	
- Cognitive impairment? (eg. delirium, dementia)			Ensure AMT4 / 4AT updated Think causes of delirium	
- Medication? (eg. sedatives, antihypertensives)			Review drug prescriptions	
- Environment? (e.g. obvious hazard, poor footwear, spectacles not worn)			Alert ward staff to identified problems	
- Other? (describe):			Other? (describe):	

Medical Review completed by:

Name

Designation

Date

Section 3 – Senior doctor and SCN review

Section 3 – Post fall review by senior doctor and SCN	
Summary of fall and detail of harm:	
Specific actions required by MDT to prevent further falls	
1.	
2.	
3.	

If this fall resulted in a serious injury i.e. fracture or head injury consider escalation to SCI process.

SCN Review completed by:		Senior Doctor review completed by:	
Name:	Designation:	Name:	Designation:
Date:		Date:	

In-patient Post Fall Multidisciplinary Review

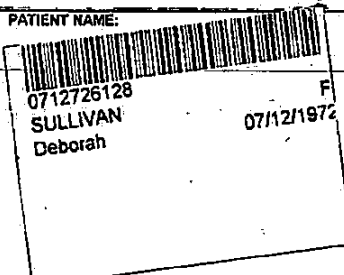
Following an in-patient fall, a 3 part multidisciplinary review must be undertaken.

- Section 1 to be completed by a registered nurse.
- Section 2 to be completed by a Junior doctor or HAN.
- Section 3 to be completed by a senior doctor and SCN to review the care delivered.

An action plan must be developed, implemented and reviewed. Learning from the review must be shared within the multidisciplinary team.

Following the incident, and the completion of this form, details must be entered into Datix by the nurse who first discovered the fall.

Section 1 - Nursing Review

SECTION 1 - TO BE COMPLETED IMMEDIATELY POST FALL BY A REGISTERED NURSE				
PATIENT NAME:  0712726128 SULLIVAN Deborah 07/12/1972		HOSPITAL: GLC	Exact location of fall: Bathroom R7	
		WARD / AREA: 65	Was the fall witnessed by staff? YES ☐ NO ☒	
		DATE OF FALL: 15/1/16	What was patient doing at time of fall? If fall was un-witnessed, ask patient. IN TOILET	
		TIME OF FALL: 17.35		
REVIEW OF CARE POST FALL	YES	NO	NA	REVIEW OF CARE
Was the patient's buzzer at hand?	☒	☐	☐	Result and date of last 4AT = on / /
Had patient pressed buzzer?	☒	☐	☐	Result of post fall 4AT = on / /
Chair and bed alarm switched on?	☐	☐	☒	Date bowels last moved / /
Previous Fall?	☐	☐	☐	Post Falls NEWS = 1 HR 105
If yes, how many?	☒ 1	☐	☐	Any signs of infection? ☐ Yes ☒ No
Known to Hospital Falls Coordinator?	☐	☒	☐	If yes, detail where
Did the patient have urine retention?	☐	☒	☐	
Did the patient have walking difficulties prior to the fall?	☐	☒	☐	
Pre fall frequency of active care prescribing 4 hrs				Post fall frequency of active care prescribing 4 hrs

Nursing Action Plan - detail action/s for future prevention and how this learning will be shared.

Provide details of any other relevant information relating to the fall here:

IMMEDIATE ACTIONS TO PREVENT FURTHER FALLS:

Person Responsible:

1.	ADVISED TO MOBILISE SLOWLY TAKE TIME AND BZZ FOR NURSE	
2.	LYING / STANDING BP	
3.	OBSERVATIONS REGULARLY	

Review of care completed by:

Name: 

Designation: D. JONES

Date: 12.4.0

Date reported in Datix: 15/1/17	Datix reference number:	Rapid Alert Reporting Process Actioned? ☐ Yes ☐ No ☐ N/A
------------------------------------	-------------------------	--

Section 2 - Medical Review

Following an in-patient fall, this review must be completed by a ward doctor/HAN in charge of the patient's care. On completion of the medical review hand this form back to nursing staff for Datix reporting. File original copy into patient notes.

Section 2 - Medical review immediately post fall by ward doctor - examine patient in bed				
ANY SIGN OF INJURY?	No (tick)	Yes (tick)	Actions:	Yes (tick)
1. Head injury?		☒	Neuro Obs (instruct nurses)	
- Neurological examination normal?		☒	CT head	
- GCS = E M V		15/15	Other (describe):	
2. Possible fracture? (examine in bed)	☒		Xray of (state site):	
- Painful limb / joint?	☒		- Urgently (discuss with senior if in doubt)	
- Tenderness / deformity any area?	☒		- Non-urgently; next day	
- Shortening / external rotation of a leg?	☒		Other (describe):	
- Change in mobility / function?				
3. Soft tissue injury?		☒	Suturing of wound	
- Cut / abrasion?		☒	Immobilisation of limb / joint	
- Bruising / sprain?	☒		Other? (describe):	
- Other? (describe):				
WHY DID THE PATIENT FALL?	No (tick)	Yes (tick)	Actions:	Yes (tick)
- Impaired balance? (eg. cerebrovascular disease, musculoskeletal disorder, neuropathy, movement disorder)		☒	Consider further examination & investigations (discuss with senior if in doubt) <i>Fibromyalgia</i>	
- Syncope? (eg. postural hypotension, arrhythmia, aortic stenosis)	☒		Auscultate heart, Lying/standing BP, Consider ECG and echo	
- Cognitive impairment? (eg. delirium, dementia)	☒		Ensure AMT4 / 4AT updated Think causes of delirium	
- Medication? (eg. sedatives, antihypertensives)	☒		Review drug prescriptions	
- Environment? (e.g. obvious hazard, poor footwear, spectacles not worn)	☒		Alert ward staff to identified problems	
- Other? (describe):			Other? (describe):	
Medical Review completed by: <u>[Signature]</u> <u>PY1</u> <u>16/1/17</u> Name Designation Date				

Section 3 - Senior doctor and SCN review

Section 3 - Post fall review by senior doctor and SCN	
Summary of fall and detail of harm: <i>Patient had a fall coming out of bathroom; legs going away (ongoing problem; red at knee) likely fibromyalgia; minor cut to forehead. Clinically well. (Cephalin)</i>	
Specific actions required by MDT to prevent further falls	
1.	
2.	
3.	

If this fall resulted in a serious injury i.e. fracture or head injury consider escalation to SCI process.

SCN Review completed by:		Senior Doctor review completed by:	
Name:	Designation:	Name:	Designation:
Date:		Date:	

Emergency Department Nursing Documentation

Presenting Complaint: Abdo pain + vomiting

Date and Time: 12/1/17

NHS
Greater Glasgow
and Clyde

Pat 0712726128
SULLIVAN
Deborah F
07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Named Nurse(s): <u>Mhann + Ross</u>	
Patient preparation (Please tick when completed)	Initials: <u>MM</u>
Prepare patient for examination and provide blankets if required	☒
Clothing bagged, labelled and stored under trolley	☒
Name-band (if required)	☐
Communication (Please tick when completed)	
Communication Aids (spectacles / hearing aid)	☐
Relatives present, who? <u>Daughter</u>	☒
Interpreters required	☐
Telephone interpretation required	☐
Observations and Investigations (Please tick when completed)	Initials: <u>MM</u>
Vital Signs recorded on NEWS chart and NEWS score recorded	☒
Record Pain, blood sugar and neuro obs on NEWS chart if appropriate	☒
Peak Flow 1. 2. 3.	☐
12 Lead ECG	☐
Cardiac Monitoring	☐
X-rays performed	☐
Other: please add	☐
Screening Tools (Please circle or tick as appropriate)	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of Infection Sepsis 6 protocol initialise and departmental documentation started	☒ Y/N
AMT 4 (if >65 years) SCORE <u>14/14</u>	☒ Y/N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). If at risk complete risk assessment	☒ Y/N
Mental Health Triage Assessment	☒ Y/N
Child Protection considered (in line with policy)	☒ Y/N
FAST	☒ Y/N
GMAWS	☒ Y/N
Has Swallow test been carried out?	☒ Y/N

Pause for Transfer (Please tick when completed)	Tick when completed	N/A	Notes
Relatives informed	☒	☐	Information on discussion with relatives
Cannula	☒	☐	
Name band	☐	☒	
AMT4	☐	☒	
NEWS chart	☒	Always	
NEWS >7 - Name and Page number of senior doctor caring for patient	☐		
Prescriptions signed	☐	☐	
Infusions	☐	☐	
Drugs	☐	☐	
Allergies are recorded (e.g. on Kardex)	☐	☐	
Fluids	☒	☐	Please note here if any other tasks required prior to transfer
Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex	☐	☐	
GMAWS	☐	☒	
Belongings (including patient's medications)	☒	Always	
Bed requested, accepted and ward informed	☒	Always	
Notes: medical notes, GP letter, PRF	☒	Always	
Investigations	☐		
CXR reviewed	☐	☐	
ECG reviewed	☐	☐	
Bloods sent	☒	☐	
Bloods reviewed	☒	☐	
Patient on O ₂ : cylinder checked	☐	☐	
Patients requiring analgesia: sufficient	☐	☐	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

[illegible]

Patient Addressograph Label

Nursing Notes and Care Plan

[illegible]



0712726128

**Hospit
Falls Co**

 SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire

07/12/1972

Service

016319

Intervention Documentation

Patient's Name	G69 7EP		Hospital/Ward: GRI 40165
CHI No.:			Age: 44 yrs
Date and reason for admission: 12/1/17 Abdo Pain + vomiting Developed @ sided weakness			
Lives alone ☐ Lives with spouse/others ☒ Nursing Hm ☐ Resid Hm ☐ Sheltered Housing ☐ Other ☐			
Referral Date/Time: 16/1/17		Assessment Date/Time: 17/1/17 11:20	
Reason for referral to Falls Coordinator:			
Multiple faller ☒ Cannard 18+ ☐ Significant injury ☐ Other ☐			
Recent Falls History:			
Falls at home: ☒ Previous Fracture/s:			
PMH: Pancreatitis			
Cholecystectomy 1996 ERCP			
IBS Fibromyalgia			
Last Cannard Score: 9		Reviewed Cannard Score: 17	
Culprit Medication Identified and No. of Meds prescribed		☐ SLA clexane Zopiclone DF118 Fentanyl Patch Oxycodone PRN x 11 meds	
Mobility Issues/Tinetti Score		☒ Under supervision	
Cognition: AMT/MMSE/MEAMS		☒ Alert + orientated	
MUST Score		☒ Score 0	
Infection		☐ Shingles	
Bone Health Screen		☐	
Postural hypotension/Cardiac		☒ @ + @ BP. Please	
Visual / hearing impairment		☐	
Continence		☐ Seeing + noctulose	
Interventions in place: ☐			
C.T. head - no significant abnormality			
lumbar puncture - await full results			
2 fully active Care			
@ + @ B.P. Please			
Refer to physio			

Code for referrals

1. Equipment advise ☐	2. General Safety Advise ☒	3. Extra support implementing documentation ☐
4. Multiple Faller ☒	5. Fracture ☐	6. Severe bruising ☐
7. Cannard 18+ ☐	8. Request for bed monitor/chair monitor ☐	9. Health & Safety referral ☐
10. Other ☐		

Date	Hospital Falls Coordinator Recommendations	0712726128 SULLIVAN Deborah 6 Muirhead Court Baillieston Glasgow, Lanarkshire 07/12/1972 F G69 7EP
17.1.17	Deborah well known to Surgical team - chronic Pancreatitis cholecystectomy and IBS. Admitted with abdo pain Lives with daughter, normally independently mobile but reports has had falls at home - G.P. felt 2° to Fibromyalgia according to Deborah. Developed photophobia and ① sided weakness since admission. C.T. head - not acute lumbar puncture - await full report Currently being treated for shingles x 2 inpatient falls due to ① leg giving way. ① postural BP drop on testing today but hypertensive - ② facial pain at time of taking BP. Advised to rest in bed and re-check BP again later. lying 173/97 standing 142/100 - staff will re-check. No surgical issues and awaits bed in medical ward. On review Deborah alert & orientated. Discussed safety awareness and the importance of using nurse call system when requiring to mobilise. She states "that she doesn't want to annoy the nurses when their so busy" I have further emphasised the importance of not getting up unaided and possible consequences of further falls i.e. injury. I have tried to re-assure Deborah that she is not annoying the nursing staff and if she was to fall again she would actually be increasing their workload. It will only take a couple of minutes for nurse to assist/supervise her to toilet. Plan - 2hly active care in situ and	

SULLIVAN, DEBORAH

ID: 0712726128

18-Nov-2015 12:33:45

ACUTE ASSESSMENT UNIT, GRI

7-Dec-1972

Female

Heart rate 74 bpm

PR interval 114 ms

QRS duration 84 ms

QT/QTc 414/459 ms

P-R-T axis -4 54 35

Normal sinus rhythm

Normal ECG

Loc: 202

Technician: 233

0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
07/12/1972
G69 7EP

Unconfirmed

aVR

V1

V4

aVL

V2

V5

II

aVF

V3

V6

150 Hz 25.0 mm/s 10.0 mm/mV

GE Healthcare by 2.5s + 1 rhythm Id

PRINTED IN U.S.A. MAC55.009A

1 0712726128

Immediate Discharge Letter

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade

Glasgow

G31 2ER

Main Switchboard: 0141 211 4000

Date of Completion: 19/11/2015

Dr. JJ Langan

Mcglone Practice

Baillieston Health Centre

20 Muirside Road baillieston

Glasgow

G69 7AD

Dear Dr JJ Langan,

Name	CHI	DoB	Address
Deborah Sullivan	0712726128	07/12/1972	6 MUIRHEAD COURT Glasgow G69 7EP

Admitted	Type	Discharged	Destination
18/11/2015 12:00	In Patient	19/11/2015	

Speciality	Consultant	Ward	Telephone
General Surgery	Mr Peter Chong	GRI Ward 65 General Surgery	0141 211-5060

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments: Dear Doctor,

This 42 year old lady was admitted on the 18/11/15 to GRI with sudden onset epigastric pain radiating to the left side associated with vomiting and dysuria. Mrs Sullivan has a background of chronic pancreatitis, cholecystectomy and laparoscopic fundoplication. Whilst in hospital, then pain did improve but was still ongoing. Most recent bloods were amylase 81. WCC 7.2 and CRP 3. We treated this as a UTI and prescribed trimethoprim and regular analgesia which allowed Mrs Sullivan to be discharged to the community. We will arrange follow up with Miss Craig in the outpatient clinic. Mrs Sullivan has otherwise been deemed surgically fit for discharge.

Yours Sincerely,
Adil Shafi
Surgical FY1

Treatments: None recorded.

Follow-up arranged: follow up with Miss Craig

Final Discharge letter y
to follow:

Medication Info:

Allergies:

Height: cm

Weight: kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Trimethoprim Tablets	Oral	200	mg	TWICE a day	5 Days	

Discontinued Medication:

Drug Name	Dose	UOM	Reason
-----------	------	-----	--------

Yours sincerely,
Dr Adl Shafi
Doctor

Prescription Review

Medications Reviewed by Pharmacist:

Dispensed Medications Checked by Pharmacy:

Nurse discharging patient: Kirsty McKenna, Nurse

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067



Shettleston Health Centre
420 Old Shettleston Rd
Shettleston
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 6212

Re: Deborah Sullivan
0712726128

Receiving Surgeons.
GRI.

18/11/15

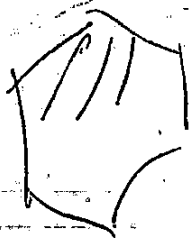
Dear colleagues,

I would be grateful for your assessment of this lady who presents with epigastric pain and back pain since last night. She has a hx of pancreatitis 2° to gallstones. She is vomiting repeated and not managing oral meds / fluids.

O/E: Apyrexial. P7S BP 122/78. Sat 98%.

YS 1+1+0.
Chest clear.

ant.



Tender ++ across
upper abdo.
ES active.
masses.

? pancreatitis

Kind Regards
~~Dr. [illegible]~~
11/5/3

Registration Details - Patient No: 16341

Personal details...		Address details...	
Date of birth	07/12/1972	Post Code	G69 7EP
Sex	F	House Name Flat No	
Surname	Sullivan	No and Street	6 Muirhead Court
Previous Surname		Village	BAILLIESTON
Forenames	Deborah	Town	GLASGOW
Calling Name	Deborah	County	
Birth Surname			
Title	Ms		
Marital Status	Marital status unknown		
Ethnic Origin	(White) British		

HA/HB Details...		Contact details...	
Trading partner	Greater Glasgow	Home Tel No	
Registered GP	Dr John Langan	Work Tel No	
Usual GP	Dr John Langan	Mobile Tel No	07568098011
Residential Inst		E Mail Address	
Branch Surgery	Baillieston Health Centre		
CHI Number	0712726128		
NHS Number			

Practice Information...		Distances	
Dispensing	N	Rural Mileage	
Hospital Number		Blocked Special	
Records At	Baillieston Health Centre	Walking Quarters	
Gpass Patient ID	B		

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	14/08/2002		
Previous Address			

AMSCMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
Pharmacy Details			
Item Collected Check	Yes		
CMS Suitability Status	-1		
CMS Registration Status	1		

Medical Record

Problems

Active Problems		Authorised By	Code
27/04/2015	Polypharmacy medication review Polypharmacy LES	Dr Walker	8B31B
09/03/2009	Chronic pancreatitis	Ms Hutchison	J671
12/10/2006	Anxiety with depression	nan	E2003
05/11/2004	Hiatus hernia NOS moderately large	UnknownUser	J34z0
26/10/2004	Nissen fundoplication using abdominal approach	UnknownUser	760L2
02/07/2002	Chronic pancreatitis	UnknownUser	J671
01/10/2001	Chronic pancreatitis	UnknownUser	J671
23/04/1999	Diaphragmatic hernia	UnknownUser	J34
23/04/1999	Reflux oesophagitis	UnknownUser	J1011

14/11/1996	[SO]Sphincter of Oddi Dysfunction	UnknownUser	7N334
10/10/1996	Endoscopic retrograde cholangiopancreatography Major papilla was located in the second part of the duodenum	UnknownUser	782Gz

Past Problems		Authorised By	Code
14/10/2009	Laparotomy and open fundoplication	Mrs Lavery	7H220
06/10/2009	Laparotomy and open revision of fundoplication	Mrs Lavery	7H220
16/02/2009	Adverse reaction to penicillins	Dr Ellor	TJ00
17/03/2004	Dislocation or subluxation of shoulder Left shoulder	UnknownUser	S41
30/08/2002	Overdose of drug Kapake and Tramadol with Diazepam	UnknownUser	SL
27/08/2002	[D]Abdominal pain Vomiting	UnknownUser	R090
02/07/2002	Constipation	UnknownUser	19C
01/07/2001	Anxiety states Chronic	UnknownUser	E200
01/07/2001	[X]Rape	Mrs Lavery	U3L
01/07/2001	Sexual assault	Mrs Lavery	TL01
27/03/1999	[D]Abdominal pain Recurrent	UnknownUser	R090
23/04/1996	Excision of gall bladder	UnknownUser	7810
23/04/1996	Cholelithiasis	UnknownUser	J64
23/04/1996	Acute cholecystitis	UnknownUser	J850
01/06/1995	Urinary tract infection, site not specified	UnknownUser	K190
01/02/1995	[D]Nausea and vomiting	UnknownUser	R070

Due Diary Entries		Authorised By	Code
27/04/2018	Cervical smear due SCCRS Recall	Mrs Campbell	685F
15/10/2016	Influenza vaccination	Mrs Young	65E..

Overdue Diary Entries		Authorised By	Code
31/10/2015	Medication review OVERDUE	Dr Walker	68314

Alerts		Authorised By	Code
None			

Drug Allergies		Authorised By	Code
16/02/2009	Adverse reaction to penicillins	Dr Ellor	TJ00

Non Drug Allergies		Authorised By	Code
None			

Health Status	
27/04/2015	Cervical smear result Cervical smear: negative
08/03/2013	Blood pressure reading O/E - BP reading
08/03/2013	Blood pressure reading 118/78 mm Hg
16/10/2015	Smoking Status Ex smoker

Consultations	
18/11/2015 08:37	Mrs Anne Nixon at Baillieston Health Centre
Comment	up all night pain in back radiating to front, very upset, in too much pain to attend surgery requesting housecall
28/10/2015 12:09	Mrs Anne Nixon at Baillieston Health Centre
Comment	07568098011 - needs duloxetine and patches
28/10/2015	Dr Julie Ellor at Telephone Consultation
Comment	doing well on meds. going to visit Dad in Aberdeen for a couple of weeks so requesting them early.
Medication	Duloxetine Gastro-resistant Capsules 60 mg 56 capsule 1 Cap Twice daily Fentanyl Transdermal patches 75 micrograms/hour 10 patch apply 1 patch

every 72 hours

16/10/2015 **Mrs Dawn Young at Baillieston Health Centre**
Social Ex smoker
Comment Influenza vacc. administratn. Generally well. No contraindications.
Additional Seasonal influenza vaccination (Left arm) Sanofi Pasteur MSD Lot M8186-1
 exp 05/2016
 Consent given for seasonal influenza vaccination

07/10/2015 **Dr Jennifer Dow at Data Entry**
Medication Duloxetine Gastro-resistant Capsules 60 mg 56 capsule 1 BD
 Fentanyl Transdermal patches 75 micrograms/hour 10 PATCH apply 1 patch
 every 72 hours

Medication

Current				
Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
28/10/2015	Fentanyl Transdermal patches 75 micrograms/hour apply 1 patch every 72 hours 10 patch	28/10/2015P	Dr Julie Ellor	ACUTE
24/06/2015	Tolterodine Tartrate Tablets 2 mg ONE TO BE TAKEN TWICE A DAY 56 tablet	07/10/2015P	Dr John Langan	REPEAT
19/01/2015	Cyclizine Tablets 50 mg 1 Tab PRN MAX TDS 100 tablet	07/10/2015P	Dr John Langan	REPEAT
30/10/2012	Quinine Sulfate Tablets 200 mg ONE TO BE TAKEN AT NIGHT 56 TABLET	07/10/2015P	Dr John Langan	REPEAT
16/08/2012	Senna Tablets 7.5 mg TAKE TWO TABLETS AT NIGHT 112 TABLET	07/10/2015P	Dr John Langan	REPEAT
11/05/2012	Hydroxychloroquine Sulfate Tablets 200 mg 2 DAILY 112 TABLET	07/10/2015P	Dr John Langan	REPEAT
29/12/2011	Esomeprazole Gastro-resistant Tablets 40 mg 1 Tab Twice daily 112 TABLET	24/08/2015P	Dr John Langan	REPEAT
22/12/2011	Tramadol Hydrochloride Capsules 50 mg ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED 224 capsule	28/10/2015P	Dr John Langan	REPEAT
22/12/2011	Temazepam Tablets 10 mg ONE TO BE TAKEN AT NIGHT 56 TABLET	07/10/2015P	Dr John Langan	REPEAT
22/12/2011	Diazepam Tablets 5 mg 1 Tab Daily 56 TABLET	07/10/2015P	Dr John Langan	REPEAT
22/12/2011	Dihydrocodeine Tartrate Tablets 30 mg ONE OR TWO TABLETS TO BE TAKEN THREE OR FOUR TIMES A DAY 224 TABLET	28/10/2016P	Dr John Langan	REPEAT
29/03/2011	Lactulose Solution 3.1-3.7 g/5 ml THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY 500 ML	07/10/2015P	Dr John Langan	REPEAT
18/11/2010	Paracetamol Capsules 500 mg 2 Caps qds 224 CAPS	28/10/2015P	Dr John Langan	REPEAT

Admission Front Sheet

Personal Details

Name:	MS Deborah Sullivan	CHI Number:	0712726128
Sex:	Female	Episode No:	I0001437621
Board Of	Greater Glasgow & Clyde	Date of Birth:	07/12/1972
Residence:		Overseas Visitor:	
Ethnicity:		Age:	42y
Occupation:		Marital Status:	Never Married (Single)
A.K.A.:		Country of Birth:	
Phone: (H):		Religion:	Not known
(W):			
(M):	07936225898		
Home Address:		Temporary Address:	6 MUIRHEAD COURT BAILLIESTON Glasgow Lanarkshire G69 7EP

Admission Details

Adm Date:	18/11/2015	Ward:	GRI Acute Assessment Unit
Adm Time:	12:00	Room:	
Significant Facility:	40-Acute Medical Unit (AMU)	Bed:	
Payor:	NHS	Adm Type:	In Patient
Consultant:	Mr Peter Chong		
Specialty:	General Surgery		

Referral/GP Details

Attend Source:
Referring Doctor: JJ Langan

Contact Details

Preferred:	Phone: (H):
	(W):
	(M):
	Relationship:

Allergy Details

Allergen	Severity
-----------------	-----------------

Date & Time	* OH Alert Allergic to Penicillin *	Signature, Print Name & Designation
	Fentanyl Patch, tolterodine cyclizine, Doxine Sulphate Senna, hydroxychloroquine esomeprazole, tramadol, temezepam diazepam, DFLB, lactulose	
	Shx ° alcohol smokes inhibitor	
	fx of family hx	
	oe Airway supported Well perfused RL 16 Sats 96% Dx clear Lx	
	Hs 112=0 HIL 70 BP 106/62 Temp 36.5	
	* unable to gain access * bloods taken	
	 ^{abdo} distended tender RUG ? localized perforation BS ✓	
	Pr/consent gained chaperone present poor tone, external haemorrhoids ? mass felt 3° ? cervix	
	* Please repeat pr *	
	° hzd stool ° blood present	
	Imp ? acute onset of chronic Pancreatitis	
	Plan/Senior review Need AXE + CxL ordered, Chase bloods once back + amylase, access, IVF, Karden Analgesia + antiemetic ? Park review	* Repeat Pr *
		lanjermid

CLINICAL NOTES - MEDICAL



Deborah

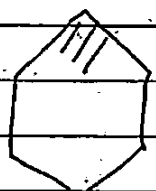
BAILLIESTON

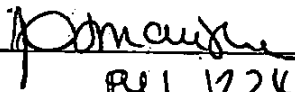
BALLISTON
Glasgow, Lanarkshire

F

07/12/1972

G69 7EP

Date & Time		Signature, Print Name & Designation
18/11/15	Keams CT2	
14.25	42Q LUQ pain	
	Onset 8pm LUQ pain	
	radiates to back on left side	
	Different to pancreatitis pain	
	Nausea vomiting	
	Constipated - BO yesterday	
	APR Blood	
	Also clo dysuria	
	PMTx - Chronic pancreatitis	
	Cholecystectomy	
	E RCP	
	Fundoplication	
	Excess alcohol.	
ole	 tender epigastrium / left flank	
	Imp. ? pyelonephritis	
	? pancreatitis	
	? par 2° constipation	
	Plan IV fluids	
	Bloods repeated as haemolyzed	
	Hold off antibiotics currently	

Date & Time		Signature, Print Name & Designation
	Mr. Thomas	
12/11/15	Hx revisited → known to Mr. Carter	
1530	C/O pain in the left flank (different to the pancreatitis pain)	
	CAP-3	
	Reports dysuria and constipation	
	Obs Stable; apyrexial.	
	Patient reports pain started suddenly - left side of the back → left flank N+V, anorexia	
	Reports pain different to pancreatitis - feels stabbing	
	Feels Constipated BM yesterday. No PR bleeding	
	Reports burning when passing urine. Urine +ve nitrate	
	Unable to take analgesia due to N&V	
	Imp: 1 pyelonephritis	
	P: Abx	
	laxatives	
	↑ dose of PPI	
	repeat bloods / chase	
		 P41 1224

CLINICAL NOTES - MEDICAL

0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire

**G69 7EP Signature, Print Name
& Designation**

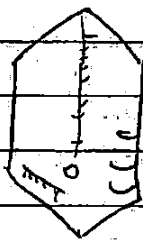
Date & Time

19/11 WR P CHONG

8 ¹⁵	Patient c/o ongoing abdominal pain (better than yesterday)	
-----------------	--	--

Amylase⁰ 81 WCC 7.2 CRP-3

Obs stable



soft
mildly tender (L) flame

Plan: ABx

analgesia

home when comfortable today

outpatient appointment (referral to Miss Craig - patient known to Miss Craig)

JO 1224

E-Pacer PATIENT REPORT

Time 11:57 Date 18/11/2015

PATIENT AND INCIDENT DETAILS

Incident number CR002529898.001
 Name DEBRA Sullivan
 Age 42y
 Date of birth 07/12/1972
 Gender Female
 CHI number 0712726128
 Incident location 6 MUIRHEAD COURT
 Incident post code BAILLIESTON GLASGOW
 Incident type G69 7EP
 URG
 Call received 18/11/2015, 09:53
 Call passed 18/11/2015, 10:56
 Crew mobile 18/11/2015, 10:56
 Crew at scene 18/11/2015, 11:16
 Crew left scene 18/11/2015, 11:40
 Receiving hospital and department GRIN Glasgow Royal Infirmary

PRIMARY SURVEY

RESPONSE
 AVPU Alert
AIRWAY
 Airway assessment Clear
BREATHING
 Breathing rate Normal
 Respiratory rate 16
CIRCULATION
 Pulse rate Normal
 Most peripheral pulse found Radial
 Cap refill rate <2 secs
 Skin colour Normal
 Skin texture Dry

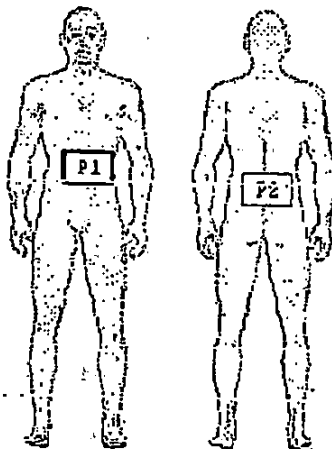
C-SPINE INJURY

Suspicion of CSI No evidence of C-spine injury

PATIENT CONSENT

Patient consent Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

INJURIES



AMPDS

Final code 01A01 Abdominal Pain

GCS

Final GCS eye opening Spontaneous
 Final GCS verbal response Orientated
 Final GCS motor response Obeys commands

VITAL SIGNS

Time hr : min	11:23	11:38
Pulse bpm	80	80
Pulse rhythm	Reg	Reg
Resp. rpm	18	16
BP mm Hg	105/63	103/66
Cap refill (secs)	<2 secs	<2 secs
Peak flow %	-	-
Blood sugar mmol/l	5.7	-
Staff / carer concern	-	-
EtCO2 mm Hg	-	-
Pain score	8/10	-
Temp °C	37.3	-
SpO2 %	100	100
SCS Total	15	15
NEWS	1	1
RTS	7.6	7.6
ECG	-	-
Sepsis	0	0
actate	-	-
AVPU	Alert	Alert

SEPSIS

Sepsis: Pneumonia
 Sepsis: UTI
 Sepsis: Other infection
 Sepsis: Abdo pain
 Sepsis: Diarrhoea
 Sepsis: Abdo distension
 Sepsis: Meningitis
 Sepsis: Cellulitis
 Sepsis: Septic arthritis
 Sepsis: Wound infection
 Sepsis: Infected indwelling device

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies
 Other allergies
 Medication
 Past history
 Last eaten
 Events prior

PENICILLIN
 AS MEDICAL RECORDS
 ANXIETY, DEPRESSION, CHRONIC
 PANCREATITIS, LOW MOOD, EXCISION
 OF GALL BLADDER 1996, RAPED 2001,
 LAPAROTOMY 2009.

SUDDEN ONSET LOWER BACK AND
 EPIGASTRIC PAIN LAST NIGHT,
 APPETITE POOR VOMITED TODAY
 AFTER EATING THIS MORNING, MOOD
 VERY LOW. WAS IN TOO MUCH PAIN TO
 ATTEND SURGERY, GP VISIT ?
 PANCREATITIS FOR REFERRAL TO GRI.

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No.	Pain after
10/10	Entonox	11:20	SELF ADMIN	Inh	-	6/10
	Entonox					

EMERGENCY SERVICES ON SCENE

Technician

PATIENT HANDOVER

On arrival at scene	Standing
Scene removal	Walking
Transportation	Lying
Care delivery at hospital	Trolley

FINAL OBSERVATION AND COMMENTS

UPPER ABDOMEN DISTENDED
 AND TENDER ? PANCREATITIS,
 HAS BEEN VOMITING
 REPEATED AND NOT

MANAGING HER ORAL MEDS

Report ID

3d0e6a0e-0c90-4540-baaf-
 0cad5f41afb

Registration Details - Patient No: 16341

Personal details...		Address details...	
Date of birth	07/12/1972	Post Code	G69 7EP
Sex	F	House Name Flat No	
Surname	Sullivan	No and Street	6 Multhead Court
Previous Surname		Village	BALLIESTON
Forenames	Deborah	Town	GLASGOW
Calling Name	Deborah	County	
Birth Surname			
Title	Ms		
Marital Status	Marital status unknown		
Ethnic Origin	(White) British		

HA/HB Details...		Contact details...	
Trading partner	Greater Glasgow	Home Tel No	
Registered GP	Dr John Langan	Work Tel No	
Usual GP	Dr John Langan	Mobile Tel No	07568098011
Residential Inst		E Mail Address	
Branch Surgery	Baillieston Health Centre		
CHI Number	0712726128		
NHS Number			

Practice information...		Distances	
Dispensing	N	Rural Mileage	
Hospital Number		Blocked Special	
Records At	Baillieston Health Centre	Walking Quarters	
Gpass Patient ID	B		

Further information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	14/08/2002		
Previous Address			

AMSCMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
Pharmacy Details			
Compliance Check	Yes		
CMS Suitability Status	-1		
CMS Registration Status	1		

Medical Record

Problems

Active Problems		Authorised By	Code
27/04/2015	Polypharmacy medication review Polypharmacy LES	Dr Walker	8B31B
09/03/2009	Chronic pancreatitis	Ms Hutchison	J671
12/10/2006	Anxiety with depression	nan	E2003
05/11/2004	Hiatus hernia NOS moderately large	UnknownUser	J34z0
26/10/2004	Nissen fundoplication using abdominal approach	UnknownUser	760L2
02/07/2002	Chronic pancreatitis	UnknownUser	J671
01/10/2001	Chronic pancreatitis	UnknownUser	J671
23/04/1999	Diaphragmatic hernia	UnknownUser	J34
23/04/1999	Reflux oesophagitis	UnknownUser	J1011
14/11/1996	[S0]Sphincter of Oddi Dysfunction	UnknownUser	7N334

10/10/1996 Endoscopic retrograde cholangiopancreatography Major papilla was located in the second part of the duodenum UnknownUser 782Gz

Past Problems		Authorised By	Code
14/10/2009	Laparotomy and open fundoplication	Mrs Lavery	7H220
06/10/2009	Laparotomy and open revision of fundoplication	Mrs Lavery	7H220
16/02/2009	Adverse reaction to penicillins	Dr Ellor	TJ00
17/03/2004	Dislocation or subluxation of shoulder Left shoulder	UnknownUser	S41
30/08/2002	Overdose of drug Kapake and Tramadol with Diazepam	UnknownUser	SL
27/08/2002	[D]Abdominal pain Vomiting	UnknownUser	R090
02/07/2002	Constipation	UnknownUser	19C
01/07/2001	Anxiety states Chronic	UnknownUser	E200
01/07/2001	[X]Rape	Mrs Lavery	U3L
01/07/2001	Sexual assault	Mrs Lavery	TL01
27/03/1999	[D]Abdominal pain Recurrent	UnknownUser	R090
23/04/1996	Excision of gall bladder	UnknownUser	7810
23/04/1996	Cholelithiasis	UnknownUser	J64
23/04/1996	Acute cholecystitis	UnknownUser	J650
01/06/1995	Urinary tract infection, site not specified	UnknownUser	K190
01/02/1995	[D]Nausea and vomiting	UnknownUser	R070

Due Diary Entries		Authorised By	Code
27/04/2018	Cervical smear due SCCRS Recall	Mrs Campbell	685F
31/10/2015	Medication review	Dr Walker	8B314

Overdue Diary Entries		Authorised By	Code
None			

Alerts		Authorised By	Code
None			

Drug Allergies		Authorised By	Code
16/02/2009	Adverse reaction to penicillins	Dr Ellor	TJ00

Non Drug Allergies		Authorised By	Code
None			

Health Status	
27/04/2015	Cervical smear result Cervical smear: negative
08/03/2013	Blood pressure reading O/E - BP reading
08/03/2013	Blood pressure reading 118/78 mm Hg
14/08/2013	Smoking Status Current smoker

Consultations	
02/09/2015	Ms Catherine Coventry at Baillieston Health Centre
Comment	past few days crushing back pain, sick
25/08/2015	Dr Jennifer Dow at Data Entry
Medication	Duloxetine Gastro-resistant Capsules 60 mg 56 capsule 1 BD
24/08/2015 13:43	Ms Lynsey Quinn at Baillieston Health Centre
Comment	duloxetine, says her dose is being put up to 120mg? so needs to prescriptions for this and fentanyl patches 075 680 98 011
19/08/2015 09:50	Mrs Anne Nixon at Baillieston Health Centre
Comment	07568098011 - in a lot of pain all night, hips and lower back

19/08/2015

History

Dr Jennifer Dow at Telephone Consultation

ptnt agress to trial 60mg bd of dulox. has meds to allow this

Medication

Current				
Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
25/08/2015	Duloxetine Gastro-resistant Capsules 60 mg 1 BD 56 capsule	25/08/2015P	Dr Jennifer Dow	ACUTE
19/01/2015	Duloxetine Gastro-resistant Capsules 30 mg 1 Cap Daily 28 capsule	27/07/2015P	Dr Gerard McKaig	ACUTE
19/01/2015	Duloxetine Gastro-resistant Capsules 60 mg 1 Cap Daily 28 capsule	27/07/2015P	Dr Gerard McKaig	ACUTE
19/01/2015	Fentanyl Transdermal patches 75 micrograms/hour apply 1 patch every 72 hours-10 PATCH	25/08/2015P	Dr Jennifer Dow	ACUTE
24/06/2015	Tolterodine Tartrate Tablets 2 mg ONE TO BE TAKEN TWICE A DAY 56 tablet	24/08/2015P	Dr John Langan	REPEAT
19/01/2015	Cyclizine Tablets 50 mg 1 Tab PRN MAX TDS 100 tablet	24/08/2015P	Dr John Langan	REPEAT
30/10/2012	Quinine Sulfate Tablets 200 mg ONE TO BE TAKEN AT NIGHT 56 TABLET	24/08/2015P	Dr John Langan	REPEAT
16/08/2012	Senna Tablets 7.5 mg TAKE TWO TABLETS AT NIGHT 112 TABLET	24/08/2015P	Dr John Langan	REPEAT
11/05/2012	Hydroxychloroquine Sulfate Tablets 200 mg 2 DAILY 112 TABLET	24/08/2015P	Dr John Langan	REPEAT
29/12/2011	Esomeprazole Gastro-resistant Tablets 40 mg 1 Tab Twice daily 112 TABLET	24/08/2015P	Dr John Langan	REPEAT
22/12/2011	Tramadol Hydrochloride Capsules 50 mg ONE OR TWO TO BE TAKEN FOUR TIMES A DAY WHEN REQUIRED 224 capsule	24/08/2015P	Dr John Langan	REPEAT
22/12/2011	Temazepam Tablets 10 mg ONE TO BE TAKEN AT NIGHT 56 TABLET	24/08/2015P	Dr John Langan	REPEAT
22/12/2011	Diazepam Tablets 5 mg 1 Tab Daily 56 TABLET	24/08/2015P	Dr John Langan	REPEAT
22/12/2011	Dihydrocodeine Tartrate Tablets 30 mg ONE OR TWO TABLETS TO BE TAKEN THREE OR FOUR TIMES A DAY 224 TABLET	24/08/2015P	Dr John Langan	REPEAT
29/03/2011	Lactulose Solution 3.1-3.7 g/5 ml THREE 5ML SPOONFULS TO BE TAKEN TWICE A DAY 500 ML	06/07/2015P	Dr John Langan	REPEAT
18/11/2010	Paracetamol Capsules 500 mg 2 Caps qds 224 CAPS	24/08/2015P	Dr John Langan	REPEAT

Sullivan, Deborah [07/12/1972] - 31 Mar 2016 - Additional Indicators

Description

- ☒ Category : Contraception
- ☒ Category : Depression
- ☒ Category : Smoking
- ☒ Category : [Extra Indicators]

Depression monitoring

Den A+R / Surgical Recovery

May thanks for seeing this patient,
PMMV + DMV attached

Acts abdominal pain and vomiting 3 hrs today
unable to keep anything down

0/R

Temp 36.6 mm 12.5 88 131/94
Sats 95% O₂A

Ant

AS ch H₂O ②

8:30



generalized hemiparesis
ep. jerks generally
8:30 ②

wp ? Acts paraneoplastic

Plan

- 3mg Buccal at 9:45 am
Admin A+R
Immediate admission

I think
8:53



Glasgow Royal Infirmary

CHI: 0712726128

Total Att: 18

12 Mth Att: 0

Title: MS

SULLIVAN

Deborah

DOB: 07/12/1972

Age: 42y

Sex: Female

6 MUIRHEAD COURT
BAILLIESTON
Glasgow
Lanarkshire

Next of kin: SULLIVAN, KATHLEEN
Relationship: Parent
771 3743

G69 7EP

GP: JJ Langan
0141 531 8050

Attendance Date: 02/09/2015

Arrival Time: 11:03

Registration Time: 11:03

Date of Incident: 02/09/2015

Major Incident Desc:

Reason for Attendance: **SFT** Epigastric pain & vomiting tachycardic in GP surgery 125 bpm

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 02/09/2015 11:05

Nurse name: Nurse Laura Mackay

Temp	36.6	C
HR	98	bpm
BP	149/59	mmHg
MAP	89.00	mmHg
RR	24	bpm
SpO2	97	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right	Pupils-Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "SFT, Left side abdo pain radiating through to back. Unrelieved by 10mg morphine. Hx pancreatitis."



0712726128
SULLIVAN
Deborah

07/12/1972



0712726128
SULLIVAN
Deborah

07/12/1972



0712726128
SULLIVAN
Deborah

07/12/1972



0712726128
SULLIVAN
Deborah

07/12/1972



0712726128
SULLIVAN
Deborah

07/12/1972

MEDICINES RECONCILIATION



0712726128
SULLIVAN
Deborah

F
07/12/1971

Patient ☒ Relative/carer ☐ GP Phone call ☐ ECS ☒

(minimum 2 sources) Patient own drugs ☐ Com. Pharmacist ☐ GP letter/summary ☐ Repeat Script ☐

Other (please specify)

Admission Medicines			Plan for medicines (Dr complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for alteration
Tolterodine	2mg	BD					
Esomeprazole	40mg	BD					
Tramadol	50 100mg	QDS PRN					
Senna	15mg	N					Not
Temazepam	10mg	N					
Hydroxychloroquine							Stopped
Paracetamol	1g	QDS					
Quinine sulphate	200mg	N					
Dihydrocodeine	30 60mg	QDS PRN					
Diazepam	5mg	OD					
Cyclizine	50mg	TDS PRN					
Duloxetine	60mg	BD					
Fentanyl 75mcg transdermal patch x1		72 hourly					Last changed yesterday 2/9/15
Lactulose	10ml	BD PRN					

Allergies

List any Over The Counter or alternative medicines

None known ☐

PENICILLIN (Rash)

Do medicines need further clarification Yes ☐ No ☒

List collected by: UM (affix)

Plan approved by:

Designation: Pharmacist Date: 3/9/15

Designation: Date:

Pharmacy review

Comments

Compliance aid: Yes ☐ No ☐

Community pharmacist

Phone

Reviewed by:

Designation:

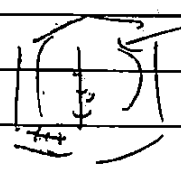
Date:



0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire.

F
07/12/1972

CLINICAL NOTES - MEDICAL

Date & Time		G69 7EP Signature, Print Name & Designation
21/11/72	Mezomies - CP - success	
13.00		
	- epigastrium & back pain for 1h	
	- radiating to LIF	
	- no dysuria / haematuria	
	- no 2hr ago	
	- no vomiting	
	- normal	
	<u>PMH:</u>	
	- post cholecystectomy pancreatitis	
	↳ pseudocyst + CP	
	- S.O.B.	
	- red red anterior fundus 2009	
	↳ other symptoms	
	- appendicitis	
	OG: distended, abt, for 15'	
	 distended, tend, tympanic	
	epigastrium	
	no herniae	
	Cx: distended stomach, no pain	
	ax: " , full body	
	CP 3, very soft, CRTs @, well 877	
	P.T.O.	

Date & Time		Signature, Print Name & Designation
2/9/15 dnd	by: 1 sheet map / acute genetic data	
	② - collect - connect - analyze	
	- NSM - VLP - NGT to donors	
	donor	
	- 2 old / CT	
	2 - 320g measures	
	VLP	



0712726128

SULLIVAN

Deborah

F
07/12/197

6 MUIRHEAD COURT

BAILLIESTON

Glasgow, Lanarkshire

G69 7EP

CLINICAL NOTES - MEDICAL

Date & Time		Signature, Print Name & Designation
2/4	WR CRAIG	D. LIAO FY1
15:30	• Pt uncomfortable in pain • Bloods unrenewable • Abdomen distended • P- Keep NG Tube in • patient analgesia • r/v tomorrow	generalised tenderness
03/09	WR	
08:30	complex pancreatic + OG hx. Pt feeling well this morning but nausea due to NG. <u>Plan</u>: OGID today in theatre	Deedley RADEN FI.
3/9/15	PHARMACY	
	Drug history completed, please find attached behind admission front sheet. Note a number of regular medicines not Rx'd, please R/v and Rx as appropriate. D/L FY1.	LMY pharmacist
3/9/15	WR Drummond	
1700	- Trial of metoclopramide for ? dysmotility. - Scope showed ? dysmotility of stomach. <u>Plan</u> ① Observe weight	KARW. KARLW PP

CLINICAL NOTES - M E-Pacer PATIENT REPORT

Time 11:04 Date 02/09/2015

PATIENT AND INCIDENT DETAILS

Incident number CR002362434.001
 Name DEBORAH SULLIVAN
 Age 42y
 Date of birth 07/12/1972
 Gender Female
 CHI number 0712726128
 Incident location 6 MUIRHEAD COURT
 BAILLIESTON GLASGOW
 Incident post code G69 7EP
 Incident type EMG
 Call received 02/09/2015, 09:44
 Call passed 02/09/2015, 09:46
 Crew mobile 02/09/2015, 09:46
 Crew at scene 02/09/2015, 10:05
 Crew left scene 02/09/2015, 10:13
 Patient at hospital 02/09/2015, 10:56
 Receiving hospital and department GRIN Glasgow Royal Infirmary

Signature, Print Name
& Designation

PRIMARY SURVEY

RESPONSE

AVPU Alert

AIRWAY

Airway assessment Clear

BREATHING

Breathing rate Normal

Respiratory rate 16

CIRCULATION

Pulse rate Fast

Cap refill rate <2 secs

Skin texture Sweaty

Circulation treatment IV cannula

Time of cannulation 10:35

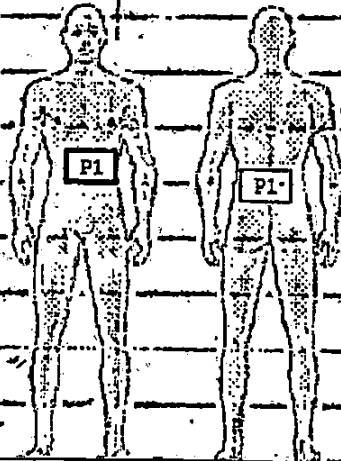
PVC record completed PVC record completed

Aseptic techniques followed Aseptic techniques followed

PATIENT CONSENT

Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment, Advice given to patient

INJURIES



Date & Time	Dispatch code 33C06	Emergency response req'd Abdominal Pain, Female Pain Above Navel => 45	ire, Print Name Designation				
	Final code 01C06						
	GCS						
	Final GCS eye opening	Spontaneous					
	Final GCS verbal response	Orientated					
	Final GCS motor response	Obeys commands					
	VITAL SIGNS						
	Time hr : min	10:10	10:15				
	Pulse bpm	123					
	Pulse rhythm	Reg					
	Resp. rpm	16					
	BP mm Hg	127 / 95 / 83	- / -				
	Cap refill (secs)	-					
	Peak flow %	-					
	Blood sugar mmol / l	6.4					
	Staff / carer concern	-					
	EtCO2 mm Hg	-					
	Pain score	5/10					
	Temp °C	37.0					
	Spo2 %	99					
	GCS Total	15					
	NEWS	2	0				
	RTS	7.6					
	ECG	NSR					
	Sepsis	1	0				
	Lactate	-					
	AVPU	-	Alert				
	SEPSIS						
	Sepsis: Pneumonia						
	Sepsis: UTI						
	Sepsis: Other infection						
	Sepsis: Abdo pain						
	Sepsis: Diarrhoea						
	Sepsis: Abdo distension						
	Sepsis: Meningitis						
	Sepsis: Cellulitis						
	Sepsis: Septic arthritis						
	Sepsis: Wound infection						
	Sepsis: Infected indwelling device						
	EYES AND PUPIL SIZE AND REACTION						
	Pupil size	Left Normal	Right Normal				
	Pupil reaction	Normal	Normal				
	AMPLE						
	Allergies	PENICILIN					
	Other allergies	SEE GP NOTES					
	Medication	PANCREATITIS.					
	Past history	>5 hrs					
	Last eaten	PT HAS PAIN IN ABDO INTO BACK, POLYURIA, VAGINAL ITCHING, NAUSEATED. GP LETTER INCLUDED. GP ARRANGED 999 QUERYING ACUTE PANCREATITIS. GP GAVE ANTIEMETIC BUT DIDNT WANT TO MASK ANY SYMPTOMS SO WITHHELD PAIN RELIEF. PT WAS 1010 PAIN SO WAS GIVEN MORPHINE 10MG AT 10:45 EN ROUTE.					
	Events prior						
	DRUGS, GASES AND PAIN RELIEF						
	Pain before	Drug / gas given	Time given	Dose given	Route	Batch No.	Pain after
	8/10	Entonox	10:10				8/10
	10/10	Morphine	10:45	10MG			5/10
	10/10	Morphine	10:45			05860814A	5/10
	EMERGENCY SERVICES ON SCENE						
	Paramedic	Technician					
	FINAL OBSERVATION AND COMMENTS						
	PAIN SINCE SUNDAY MORNING.						
	Report ID	aa6c58b8-68c1-4799-80fe-4e4b8f38b415					

Immediate Discharge Letter

Greater Glasgow
and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No

Glasgow Royal Infirmary
Alexandra Parade

Glasgow

G31 2ER

Main Switchboard: 0141 211 4000

Date of Completion: 07/09/2015

Dr. JJ Langan
McGlone Practice
Baillieston Health Centre
20 Muirside Road baillieston
Glasgow
G69 7AD

Dear Dr. JJ Langan,

Name	CHI	DoB	Address
Deborah Sullivan	0712726128	07/12/1972	6 MUIRHEAD COURT Glasgow G69 7EP

Admitted	Type	Discharged	Destination
02/09/2015 14:01	In Patient	04/09/2015	

Specialty	Consultant	Ward	Telephone
General Surgery	Miss Carol Craig	GRI Ward 64 General Surgery	0141 211 4453

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Doctors,
this 42 year old female was admitted to general surgery ward in Glasgow Royal Infirmary on 02/09/2015.
She presented with left sided abdominal pain radiating through to the back associated with vomiting. She denied urinary and bowel symptoms. On admission she was tachycardic, all other obs were stable. Blood results were unremarkable. In a view of her extensive past medical history she underwent endoscopy. This revealed normal stomach with small amount of food residue, suggestive of oesophageal/gastric dysmotility. Therefore she was commenced on Metoclopramide.
Her symptoms have resolved and she was discharged.
Thank you for ongoing care of Ms Sullivan.
Kind regards,
Joanna Osmanska

Treatments: None recorded.

Follow-up arranged: None

Planned Outpatient: None

Investigations:

Final Discharge letter Yes
to follow:

Medication Info:

Allergies:

Height: cm

Weight: kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Clotrimazole 1% Cream	Topical	1	application	THREE Times a Day	7 Days	Morning, lunchtime and afternoon
Cyclizine Tablets	Oral	50	mg	THREE Times a Day	Indefinite	Max every 8 hours
Diazepam Tablet	Oral	5	mg	In the Morning	Indefinite	
Dihydrocodeine Tartrate Tablets	Oral	60	mg	FOUR Times a Day	Indefinite	Every 6 hours for pain
Duloxetine Capsules	Oral	60	mg	Every morning and night	Indefinite	
Fentanyl 75micrograms/hr Patch	Topical	1	patch(es)	As Directed	No duration defined	To be changed every 72 hrs, next due 5/09
Metoclopramide Tablets	Oral	10	mg	THREE Times a Day	5 Days	Morning, lunchtime and teatime
Omeprazole Capsules	Oral	20	mg	In the Morning	Indefinite	
Paracetamol Tablets	Oral	1000	mg	As Required	7 Days	Max every 6 hours for pain
Paracetamol Tablets	Oral	1000	mg	As Required	Indefinite	Max every 6 hours for pain
Quinine Sulphate Tablets	Oral	200	mg	At Night	Indefinite	
Senna Tablets	Oral	15	mg	At Night	Indefinite	
Temazepam Tablets	Oral	10	mg	At Night	Indefinite	
Tolterodine Tartrate Tablets	Oral	2	mg	Every morning and night	Indefinite	
Tramadol Capsule	Oral	100	mg	FOUR Times a Day	Indefinite	Every 6 hours

Medication Comment: Professional Screen. R Cord, Pharmacist. Only metoclopramide to be supplied from pharmacy.

Discontinued Medication:

Drug Name	Dose	UOM	Reason
-----------	------	-----	--------

Yours sincerely,
Dr Joanna Osmanska
Doctor

Prescription Review

Medications Reviewed by Pharmacist: Robbie Cord, Pharmacist

Dispensed Medications Checked by Pharmacy: Michelle Roberts, Technician

Nurse discharging patient: Margaret Toner,

ID:

2-Sep-2015 11:18:39

ACUTE ASSESSMENT UNIT, GRI



0712726128

SULLIVAN

Deborah

6 MUIRHEAD COURT

BAILLIESTON

Glasgow, Lanarkshire

07/12/1972

F

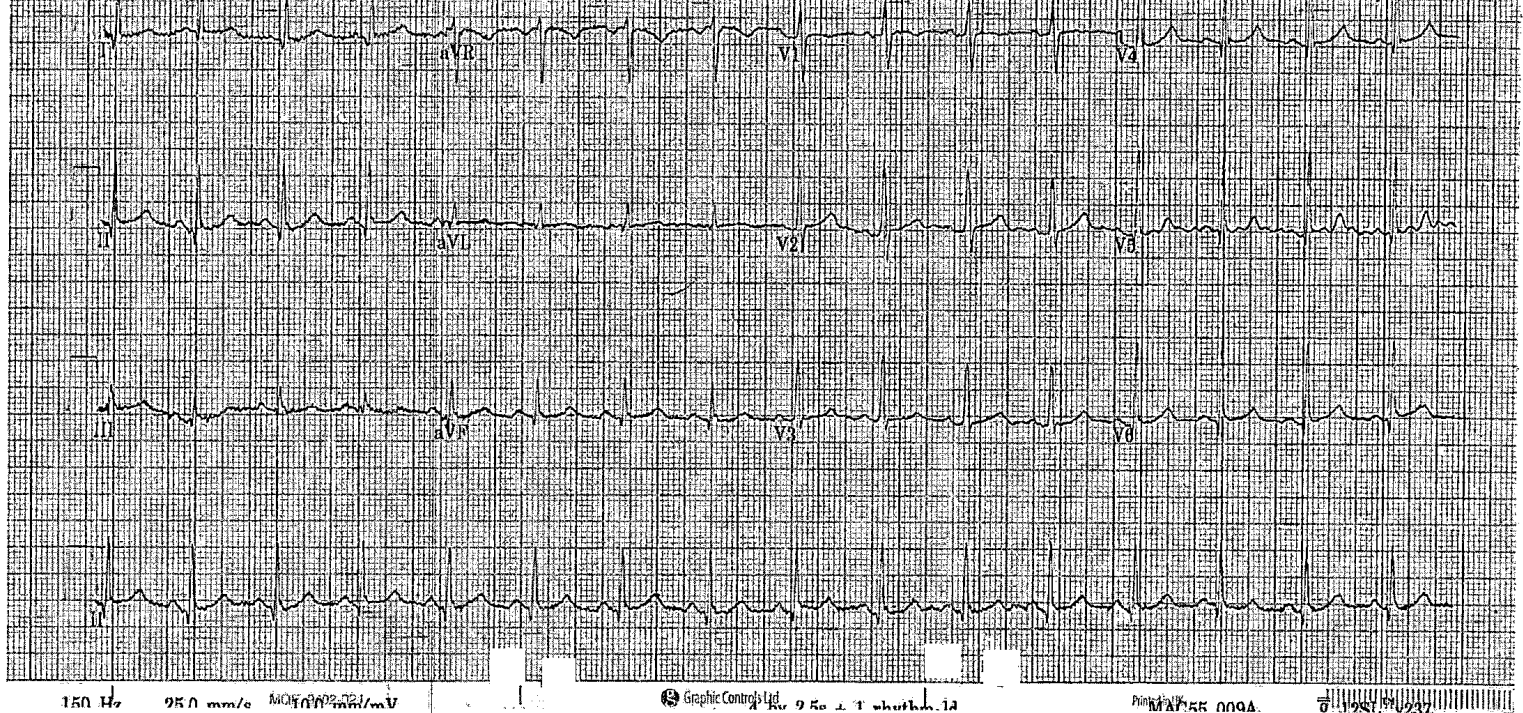
G69 7EP

Heart rate 95 bpm
PR interval 132 ms
QRS duration 78 ms
QT/QTc 364/457 ms
P-R-T axes 57 42 43

Normal sinus rhythm
Increased R/S ratio in V1, consider early transition or posterior infarct
Abnormal ECG

Unconfirmed

*epigastric pain
w/odynophagia*



0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

The patient attended GA Clinic at
Hospital on 7 6 27 and I would advise a change to drug therapy from
to
or additional therapy of

as detailed below. Full letter to follow.

Additional Comments:

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE
--------------	------	-----------	------------------------

FRUSTRATION
FOR DELAYED CASE 1/10/13

Yours Sincerely

Signature:

Name (print)

Grade:

Ext. No:

Deborah Sullivan

GP

To be completed by the Clinical Practitioner

The clinician completing this form should have sufficient knowledge of the proposed investigation or treatment in order to provide the patient with the appropriate information.

Notes for Clinician

A patient has the right to grant or withhold consent prior to these investigations. The clinician must give the patient enough time to read this form and enough information, in a way they can understand about the proposed procedure, significant side effects and any alternatives. The patient must be allowed to decide whether they will agree to the procedure and they may refuse or withdraw consent to a procedure at any time.

I have fully explained to the:

Patient, Parent, Guardian or Next of Kin
(delete as appropriate)

1. The procedure named on this form
2. The significant side effects which may result from the procedure

Name and Grade: Shona Thomson

Date: 25/10/2022

Prepared by Sr. Shona Thomson Sept 2010
Review date - Sept 2020

MI • 234513

Glasgow Royal Infirmary

**Oesophageal Function
Gastroenterology Department**



Name: 

Hospital Number: _____

Address: SULLIVAN

Deborah 07/12/1972 F
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire G34 9JE

D.O.B. _____

Telephone No _____

Consultant: DR Ruth Gillespie

Referring Clinic or Hospital: OC - GRZ

Investigation Date: 25/10/22

Procedure: HRM + 24hr ph on med

Screening Time: _____

cGycm

min

Nursing Documentation as per eForm on clinical portal.

Anti reflux surgery x2. Delayed gastric emptying
Nursing Notes: Dysphagic heartburn

Fasted Yes Allergic Penicillin

PMX

Fibronygel

TBP

Diabetic Insulin 12bbel

BM 6.7mmol

Esomeprazole 40mg BD - on med study

BM 6.1mmol

Oesophageal Manometry

Lower Oesophageal Sphincter - Position of high pressure zone

Type of cath

Customized Single-Use Esophageal 24ch Catheter 12F -- Disposable

REF 2025-08 AHC HR2412

Central Decontamination

LOT 210720-D

Serial Number:

To be completed by the: Patient, Parent, Guardian or Next of kin

You should read this form and the notes below carefully. If there is anything you do not understand please ask for an explanation. If for any reason you are not satisfied with the explanation you are entitled to refuse the procedure. If you are happy with this and wish to proceed you should sign this form.

This procedure involves passing a thin, soft tube into your gullet (oesophagus) via your nostril. It is a safe procedure but is sometimes associated with some minor discomfort in your nose or throat and a runny nose. It can occasionally make you feel faint. For some tests the tube remains in place for 24 hours and we may have to ask you to follow some restrictions in your diet and activity.

You may ask for a relative or a nurse to be present while the clinician explains the procedure and asks you to sign the form.

I am The patient, parent, guardian or next of kin
(delete as appropriate)

I understand The purpose, benefits and significant risks associated with the procedure, which have been explained to me by the clinician on this form.

Please tick the appropriate box if you agree or disagree to any of the following

To the procedure named on this form I Agree ☐ I Disagree ☐

Students need to learn and observe how procedures are done. A student may be present during the procedure

To examination by a student during procedure named on this form under supervision of the senior clinician undertaking the procedure I Agree ☒ I Disagree ☐

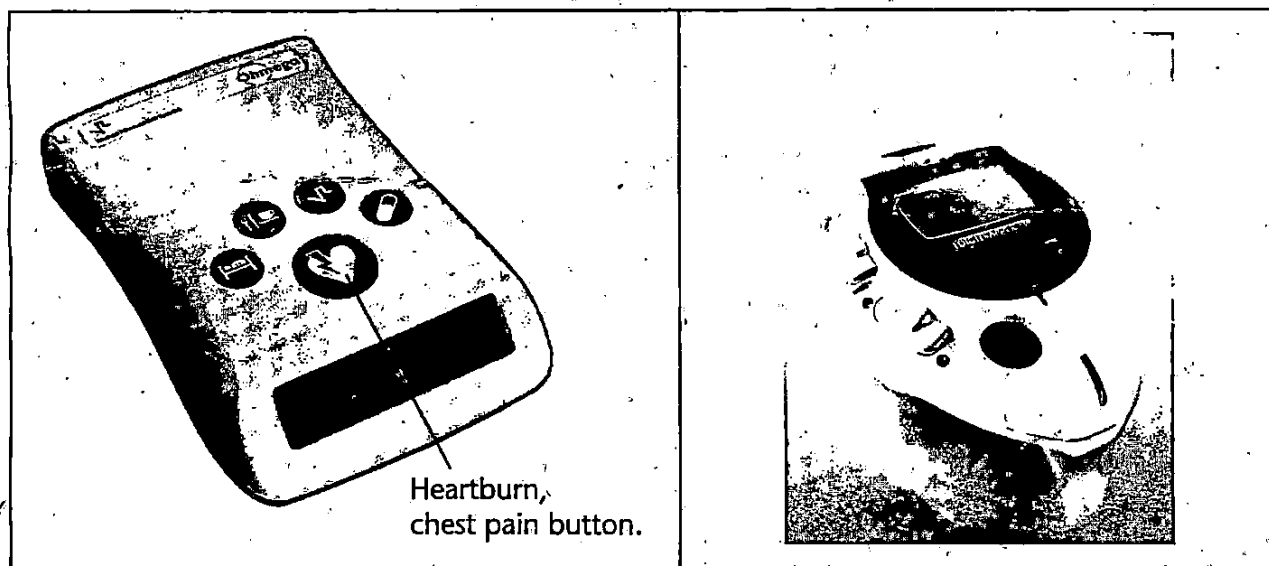
Signature:

Date: 25/10/22

Ambulatory PH and, or Impedance Study – Patient Diary

Name: CHI Number:		Date:
 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE		25/10/2020
Comments:		
Intubation (please tick):		
1) right nare ☐	2) left nare ☐	3) the mouth ☐
Any technical difficulties during intubation:		
Customized Single-Use Esophageal 24ch Catheter 12F REF AHC HR2412 2025-08 LOT 210720-D		

We have given you an Ambulatory PH Recording Device to monitor the amount of fluid coming up (reflux) into your oesophagus (gullet).



Please complete this diary to record the start and finish times of the following:

-  When eating and drinking - it is helpful if you record which food you have eaten.
-  When lying down or asleep - you can place the recording device under your pillow.
-  Episodes of heartburn or chest pain - you only need to record when these start.

Start Time	Event:	Finish Time
2.40 pm	DRINK JUICE	2.42
2.42 pm	Biscuit	2.47
3.00 pm	Mash Burger Beans	3.20
18.35	Lying down	19.40
19.40	Tea	19.50

Start Time	Event:	Finish Time
20-00	Porridge	20-10
20-25	Lying down	
07.36	Breakfast	
7-36	UP	
07.40	Boiling water	
8.00	Porridge	8.15
8.00	Coffee	8.30
8.40	Water	11.00
When lying down or sleeping: Start Time: 18.35 Lying down 20.25 Lying down Finish Time: 19.40 07.36		

Returning the Ambulatory PH Recording Device:

You will need to come back to the hospital to return the device at the specified time:

- Patients attending a 9:00am or 11:00am appointment should return between 09:00 am and 10:00am the next day.
- Patients attending a 1:30pm or 3:00pm appointment should return at 12 midday the next day.

The recorder device must be returned to the Gastroenterology Day Unit, Glasgow Royal Infirmary.

How to care for the Ambulatory PH Recording Device:

- Do not allow the device to come into contact with water or household agents such as bleach.
- If the catheter (the tube) is coughed into the mouth, you can remove it by pulling it from the nose. Do not try to re-insert the tube. Make a note of the time that your removed the tube.
- The Gastroenterology Day Unit is open Monday to Friday 8.00am to 4.00pm. If you need advice outside these hours please contact NHS 24 on 111 or our local Accident and Emergency Department.

BAY 10



0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Date: 23/09/25 Consultant / Endoscopist: Fiona Beck

Patient liked to be known as: DEBBIE

Procedure

Gastroscopy ☒ E.R.C.P. ☐ EBUS ☐
Colonoscopy ☐ E.U.S. ☐ Enteroscopy ☐
Sigmoidoscopy ☐ Bronchoscopy ☐ Thoracoscopy ☐

Discharge Arrangements

Name of Escort /contact Courtney	Escort Required Yes ☒ No ☐	Overnight supervision arranged Yes ☒ No ☐
Relationship Daughter	Escort to be contacted Yes ☒ No ☐	Overnight stay in ward Yes ☐ No ☒
Contact tel no 074 812 57039		

Have you received Patient Information and understood it: Yes ☒ No ☐

Medical History and Pre Procedure check

Condition	Yes	No	Details
Diabetes	☒	☐	Type 1 ☒ Type 2 ☐ insulin
Angina/ Ischaemic heart Disease	☐	☒	
Hypertension	☒	☐	
Myocardial Infarction	☐	☒	Date:
Artificial valves	☐	☒	
Pacemaker	☐	☒	
CABG	☐	☒	
Coronary artery stent	☐	☒	
Stroke/TIA	☐	☒	
Asthma	☐	☒	
COPD	☐	☒	
Epilepsy	☐	☒	
Liver disease	☐	☒	
Arthritis	☐	☒	
Orthopaedic implants	☐	☒	Specify:
Glaucoma	☐	☒	
Anaemia	☐	☒	
Recent surgery	☐	☒	
Previous endoscopy	☒	☐	
CJD/VCJD risk	☐	☒	
Other	☐	☐	



0712726128

SULLIVAN

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux	☒	☐	
Dysphagia	☐	☒	
Barretts	☐	☒	
Oesophageal/Gastric Varices	☐	☒	
Gastric ulcer	☐	☒	
Altered bowel habit	☐	☒	
PR bleeding	☐	☒	
Crohns disease	☐	☒	
Ulcerative colitis	☐	☒	
Surveillance colonoscopy	☐	☒	
Screening programme	☐	☒	
Other:	☐	☐	

Mobility Assessment

Independent Yes ☒ No ☐ If No, complete all questionsAids and/ or assistance required Yes ☐ No ☐ *sometimes*Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ SpecifySight impairment Yes ☐ No ☒ if yes specify

Communication Needs (answer only applicable question)

Hearing impairment Yes ☐ No ☒Hearing aid Yes ☐ No ☐ right ear ☐ left ear ☐ both ears ☐Sign Interpreter required Yes ☐ No ☐Lip reads Yes ☐ No ☐Interpreter Required Yes ☐ No ☐ LanguageInterpreter present Yes ☐ No ☐Relative / friend present Yes ☐ No ☐

The use of relatives and friends as interpreters is discouraged unless it is the patient's choice to use them.

Learning Disability Yes ☐ No ☐ Carer present Yes ☐ No ☐Dementia Yes ☐ No ☐ Incapacity form completed Yes ☐ No ☐

Current Medication (list below and tick those taken today)

Humulin I

Diazepam	Aniprazole	Simvastatine	
Empagliflozin	Procyclidine	Ramipril	
Verapamil	Creon 10000	Rybelsus	
Pregabalin	Metformin	Sucralfate	
Orbansetron	esomeprazole	Mirtazipine	

Reptac

ANTICOAGULANT THERAPY Yes ☐ No ☒ If yes current medication

When was this medication last taken Specify

INR Result

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Admission Observations

BP 121/80 Pulse 90 Oxygen Saturation 93/100

BM (if applicable) 12.1mmol Respirations (if applicable) 16

Fasted since 22.00 22/9/25

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor						

Patient Requests

Throat Spray ☐ IV Sedation ☒ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)
		<u>Blue</u> <u>22.00.51</u>				

Dentures removed (if applicable) Yes ☐ No ☒

Crowns Yes ☐ No ☒ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Bridgework Yes ☐ No ☒ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Identiband details checked Yes ☐ No ☐

Consent form signed Yes ☐ No ☐

Consent form countersigned Yes ☐ No ☐

Underwear removed (if applicable) Yes ☐ No ☐

Jewellery removed Yes ☐ No ☐

ALLERGIES

Yes ☒ if yes detail below No ☐

*Details penicillin *

Name of Admission Nurse (Print) DEBORAH SULLIVAN

Signature of Admission Nurse [Signature]

Patient's Declaration

I have read and understood the warnings regarding the after effects of sedation.

Patient's signature [Signature]



0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
07/12/1972
G34 9JE

Intra Procedure

Endoscopist (print) Beck

Endoscopy Room Nurses (print) Smith, McAuley, O'Neill

Surgical Pause carried out Yes ☒ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray						
Midazolam	☒		1039	2 mg	IV	FB
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl				mcg		
Fentanyl				mcg		
Fentanyl				mcg		
Buscopan				mg		
Buscopan				mg		
Buscopan				mg		
Antibiotics						
				mg		
				mg		
				mg		
Reversal Agents						
				mg		
				mg		
Local anaesthetic						
				mg		
				mg		
Other						
Botox				mg		
Xylocaine	☒		1035	20 sprays	Topical	
Prescribed by.....						

Endoscopist Signature.....

Start Time 1041 Finish Time 1045

Patient position Left Lateral ☒ Supine ☐ Prone ☐ All ☐

Oxygen therapy Yes ☒ No ☐ nasal sponge ☐ cannula ☒ mask ☐ rate 2L



0712726128

SULLIVAN

F

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Observations during procedure

Time	1040					
Pulse	78					
SpO2	97%					
BP						
Resps						

Procedure (please tick all relevant)

Gastroscopy	☒	Biopsy	☒	Varices		Adrenaline	
Colonoscopy		Hot Biopsy		Gastric Ulcer		Spot Dye	
Sigmoidoscopy		Snare Polypectomy		Duodenal Ulcer		Indigo Carmine	
E.R.C.P.		Balloon dilatation		Oesophagus		Gelofusine	
E.U.S		Injection		Duodenum		Normal Saline	
Bronchoscopy		Laser		Biliary		Haemospray	
E.B.U.S		Heater Probe		Pancreatic			
Thoracoscopy		Endo clip		Haemorrhoids			
Enteroscopy		Insertion of Stent		Rectum			
		EMR		Sigmoid			
		PEG		Descending			
		Needle Aspiration		Splenic flexure			
		Brushings		Transverse			
		Washings		Hepatic flexure			
		Banding		Ascending			
		Insert of NJ tube		Caecum			
		Gastric Pacing Wire		Terminal Ileum			

Other Gastric Bx

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	
Drowsy	☒	One or two episodes of mild discomfort, well tolerated	
Awake		More than two episodes of discomfort, adequately tolerated.	
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments

P+ reassured throughout

Specimens Yes ☒ No ☒Pathology ☐ No of pots H pylori test ☐ bacteriology ☐ cytology ☐ mytology ☐



0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Diathermy Yes ☐ No ☒ Type mono ☐ Argon ☐
Site of diathermy pad leg ☐ back ☐ R side ☐ L side ☐ Upper ☐ Lower ☐
Other
Condition of skin post diathermy normal ☐ other ☐ comment below

Recovery Room Instructions (if applicable)

Oxygen 4 litres per minute if SpO2 drops below 95% ☒
Oxygen 4 litres per minute until fully awake ☐
Oxygen per minute via until ☐
Normal Diet ☒ Fluids only ☐ Soft Diet ☐ Nil orally till further medical instructions ☐
NB 11:10
To be seen by endoscopist before discharge ☐
Further Instructions OK for report

Endoscopy Room Nurse Signature

Recovery care

Post endoscopy observations

Time	10.50	11.05	11.30	11.35					
Blood pressure	104/73	102/66	91/58	121/75					
Pulse	81	79	89	85					
O2 Saturation	97%	98%	95%	96%					
Respiratory Rate	16		14	14					
Sedation score	1	1	0	0					
Pain score	1	3	0	0					
Oxygen	Air	Air	Air	Air					
IV Cannula	(R) 20G	(L) 20G	2	12					
BM	20g								
Nurse initials	WJ	WJ	TB	TB					

Pain score 0 = no pain, 1 = minimal, 2 = mild, 3 = moderate, 4 = severe

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive



0712726128

SULLIVAN

F

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Nurses notes

22/9/25 - Pt pre Admitted over the phone No issues

23/9/25 2nd time to Opt at 0940

- Consent + checklist completed

- 2005 Stickle

- Version in situ for Sedation

- current procedure

0830

52



0712726128

SULLIVAN

F

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Discharge Criteria

	Yes	No
Stable vital signs	☒	☐
Alert and Orientated	☒	☐
Pain score is 2 or below	☒	☐
Diet and fluids taken	☒	☐
IV Cannula removed	☒	☐
Received written instructions regarding sedation	☒	☐
Received verbal and written aftercare instructions	☒	☐
Patient Advice Leaflet given (if applicable)	☐	☐

Received Endoscopy Report/ Patient letter

Yes ☒No ☐

If no

Verbal report by endoscopist ☐

Follow up appointment indicated on report

Yes ☐No ☒

Follow up appointment (if given in department)time

Comments.....

.....

.....

I confirm patient is satisfactory for discharge

Print Name M. Kilmorad Signature M. Kilmorad

Discharged at 11.50 to care of Daughter

Irregular discharge Reason

.....

Patients' Signature Nurses Signature

Consent Form

Patient agreement to endoscopic investigation or treatment

Pa	
0712726128	F
SULLIVAN	
Deborah	07/12/1972
Flat 0-1, 8 Boyndie Street	
Easterhouse	
Glasgow, Lanarkshire	
G34 9JE	

Name of Procedure

Gastroscopy: Endoscopy: Oesophago-gastro-duodenoscopy

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography)

Biopsy specimens will be retained.

Statement of Patient

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in this booklet including the benefits and any risks.

I agree to the procedure described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner.

I understand that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I would like to have: ~~local anaesthetic throat spray~~ ☐
or sedation ☒ (Please tick box)

Have you ever been notified that you are at an increased risk of CJD or VCJD for public health purposes?

☐ Yes ☒ No

Consent Signature

Please Use Black Ink

Signed: *Deborah Sullivan* Date: 23/9/25

Name (print in capitals): DEBORAH ELIZABETH SULLIVAN

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signed: _____ Date: _____

Staff Only

Confirmation of consent (to be completed by a health care professional when the patient is admitted for the procedure)

I have confirmed that the patient understands what the procedure involves including any risks.

I have confirmed that the patient has no further questions and wishes the procedure to go ahead.

Signed: *Debbie Bell* Date: 23/9/25

Name (print in capitals): DEBBIE BELL

Job Title: SN

Next Steps after your Endoscopy Procedure



Thank you for attending for your endoscopy procedure on

23/9/25

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

The clinician who performed your endoscopy was:

F. Beck

You should have received a copy of your endoscopy report to take away with you which contains important information about your procedure. Please speak to a member of the nursing team if you do not have a copy of this.

Your clinician will have explained the next steps after your endoscopy procedure. It is important that you remember the following points if they are applicable to your care.

Next steps in your care	Applicable to you	
	Yes	No
You had biopsies taken or polyps removed during your procedure and you should receive the results in 12 weeks. If you have not heard about your results after 12 weeks please call: 0141 201 3682	✓	
You need to attend for a repeat procedure in _____. If you have not had an appointment 2 weeks before this date please call: 0141 201 3682		✓
No biopsies taken – follow up to be determined by the clinician who requested your endoscopy		✓
You do not need any follow up and will be discharged to the care of your GP.	✓	

For staff:

Completed by:

M. Kirkwood

Designation:

C/N

Date:

23/9/25



0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

G34 9JE

Date: 05/12/20 Consultant / Endoscopist: Prof McKay

Patient liked to be known as:

Procedure

Gastroscopy ☐ E.R.C.P ☐ EBUS ☐
Colonoscopy ☐ E.U.S ☒ Enteroscopy ☐
Sigmoidoscopy ☐ Bronchoscopy ☐ Thoracoscopy ☐

Covid-NEG
(03/12/20)

Discharge Arrangements

Name of Escort /contact COURTNEY	Escort Required Yes ☒ No ☐	Overnight supervision arranged Yes ☒ No ☐
Relationship DAUGHTER	Escort to be contacted Yes ☒ No ☐	Overnight stay in ward Yes ☐ No ☒
Contact tel no 07487257039		

Have you received Patient Information and understood it: Yes ☒ No ☐

Medical History and Pre Procedure check

Condition	Yes	No	Details
Diabetes	☒	☐	Type 1 ☐ Type 2 ☒
Angina/ Ischaemic heart Disease	☐	☒	
Hypertension	☐	☒	
Myocardial Infarction	☐	☒	Date:
Artificial valves	☐	☒	
Pacemaker	☐	☒	
CABG	☐	☒	
Coronary artery stent	☐	☒	
Stroke/TIA	☐	☒	
Asthma	☐	☒	
COPD	☐	☒	
Epilepsy	☐	☒	
Liver disease	☐	☒	
Arthritis	☐	☒	
Orthopaedic implants	☐	☒	Specify:
Glaucoma	☐	☒	
Anaemia	☐	☒	
Recent surgery	☐	☒	
Previous endoscopy	☒	☐	
CJD/VCJD risk	☐	☒	
Other	☐	☐	

071276128
SULLIVAN
Deborah

F
07/12/1972

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux	☒		
Dysphagia		☒	
Barretts		☒	
Oesophageal/Gastric Varices		☒	
Gastric ulcer		☒	
Altered bowel habit		☒	
PR bleeding		☒	
Crohns disease		☒	
Ulcerative colitis		☒	
Surveillance colonoscopy		☒	
Screening programme		☒	
Other:			Perious Pancreatitis

Mobility Assessment

Independent Yes ☐ No ☒ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☒

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify

Sight impairment Yes ☐ No ☒ if yes specify

Communication Needs (answer only applicable question)

Hearing impairment Yes ☐ No ☒

Hearing aid Yes ☐ No ☒ right ear ☐ left ear ☐ both ears ☐

Sign Interpreter required Yes ☐ No ☒

Lip reads Yes ☐ No ☒

Interpreter Required Yes ☐ No ☒ Language

Interpreter present Yes ☐ No ☒

Relative / friend present Yes ☐ No ☒

The use of relatives and friends as interpreters is discouraged unless it is the patient's choice to use them.

Learning Disability Yes ☐ No ☒ Carer present Yes ☐ No ☒

Dementia Yes ☐ No ☒ Incapacity form completed Yes ☐ No ☒

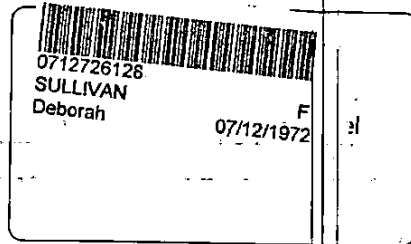
Current Medication (list below and tick those taken today)

Alogliptin		Prochloridone		Doloxetine	
Metformin		Iaxido Orange		Pregabalin	
Ondansetron		Paracetamol		Simvastatin	
Diazepam		lactulose		Ramipril	
Cream 10.000		Esomeprazole		Rizatriptan Benzocaine	
Temazepam		Anaprazole		Mirtazapine	

ANTICOAGULANT THERAPY Yes ☐ No ☒ If yes current medication HA Glicazide

When was this medication last taken Specify

INR Result



Admission Observations

BP 113/94 Pulse 110 Oxygen Saturation 97%
BM (if applicable) N/A Respirations (if applicable) Norm
Fasted since Food 11 PM
Drugs

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor						N/A

Patient Requests

Throat Spray ☐ IV Sedation ☒ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)

Dentures removed (if applicable) Yes ☐ No ☒

Crowns Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Bridgework Yes ☐ No ☐ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐

Identiband details checked Yes ☒ No ☐

Consent form signed Yes ☒ No ☐

Consent form countersigned Yes ☒ No ☐

Underwear removed (if applicable) Yes ☐ No ☒

Jewellery removed Yes ☐ No ☒

ALLERGIES Yes ☒ if yes detail below No ☐

Details *Penicillin*

Name of Admission Nurse (Print) N. Love ANN ALVICKATZ

Signature of Admission Nurse W. Love

Patient's Declaration

I have read and understood the warnings regarding the after effects of sedation.

Patient's signature D. Seelen



071226128
SULLIVAN
Deborah

F
07/12/1972

Intra Procedure

Endoscopist (print) Prof. McKay

Endoscopy Room Nurses (print) D. Levey, Love, Apolina

Surgical Pause carried out Yes ☒ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray	☒		08:31	X10 Spray	Oral	Love
Midazolam	☒		08:32	1 mg	IV	McKay
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl	☒		08:32	75 mcg	IV	McKay
Fentanyl				mcg		
Fentanyl				mcg		
Buscopan				mg		
Buscopan				mg		
Buscopan				mg		
Antibiotics				mg		
				mg		
				mg		
Reversal Agents				mg		
				mg		
Local anaesthetic				mg		
				mg		
Other				mg		
Botox				mg		
Prescribed by						

Endoscopist Signature

Start Time 08:33 Finish Time 08:40

Patient position Left Lateral ☒ Supine ☐ Prone ☐ All ☐

Oxygen therapy Yes ☒ No ☐ nasal sponge ☐ cannula ☐ mask ☐ rate 2L



0712726128
SULLIVAN
Deborah

07/12/1972

Observations during procedure

Time	08.30	08.40				
Pulse	86	87				
SpO2	97	97				
BP						
Resps						

Procedure (please tick all relevant)

Gastroscopy		Biopsy		Varices		Adrenaline	
Colonoscopy		Hot Biopsy		Gastric Ulcer		Spot Dye	
Sigmoidoscopy		Snare Polypectomy		Duodenal Ulcer		Indigo Carmine	
E.R.C.P.		Balloon dilatation		Oesophagus		Gelofusine	
E.U.S		Injection		Duodenum		Normal Saline	
Bronchoscopy		Laser		Biliary		Haemospray	
E.B.U.S		Heater Probe		Pancreatic			
Thoracoscopy		Endo clip		Haemorrhoids			
Enteroscopy		Insertion of Stent		Rectum			
		EMR		Sigmoid			
		PEG		Descending			
		Needle Aspiration		Splenic flexure			
		Brushings		Transverse			
		Washings		Hepatic flexure			
		Banding		Ascending			
		Insert of NJ tube		Caecum			
		Gastric Pacing Wire		Terminal Ileum			

Other

Sedation score	Tick	Comfort Score	Tick
Asleep	☒	None, resting comfortably	☒
Drowsy	☐	One or two episodes of mild discomfort, well tolerated	☐
Awake	☐	More than two episodes of discomfort, adequately tolerated.	☐
	☐	Significant discomfort experienced several times	☐
	☐	Extreme discomfort frequently during procedure	☐
Comments			

Specimens Yes ☐ No ☒

Pathology ☐ No of pots H pylori test ☐ bacteriology ☐ cytology ☐ mytology ☐



0712726123
SULLIVAN
Deborah
Flat 0-1, 4 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
07/12/1972
G34 9JE

Diathermy Yes ☐ No ☒ Type mono ☐ Argon ☐

Site of diathermy pad leg ☐ back ☐ R side ☐ L side ☐ Upper ☐ Lower ☐

Other

Condition of skin post diathermy normal ☐ other ☐ comment below

Recovery Room Instructions (if applicable)

Oxygen 4 litres per minute if SpO2 drops below 95% ☒

Oxygen 4 litres per minute until fully awake ☐

Oxygen per minute via until ☐

Normal Diet ☒ Fluids only ☐ Soft Diet ☐ Nil orally till further medical instructions ☐

To be seen by endoscopist before discharge ☐

Further Instructions

Endoscopy Room Nurse Signature *CA*

Recovery care

Post endoscopy observations

Time	8.40	8.55												
Blood pressure	99/54	92/52												
Pulse	82	83												
O2 Saturation	98%	99%												
Respiratory Rate	Norm	Norm												
Sedation score	A	A												
Pain score	0	0												
Oxygen	-	-												
IV Cannula	✓	✓												
BM	-	-												
Nurse initials	AD	AB												

Pain score 0 = no pain, 1 = minimal, 2 = mild, 3 = moderate, 4 = severe

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive



0712726128

SULLIVAN

Deborah

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

07/12/1972

G34 9JE

Nurses notes

16³⁰ 04/12/20 - PREADMITTER OVER THE PHONE. PATIENT AWARE OF
PROCEDURE & FASTING & SEDATION REQUIREMENTS. N. LOG.

071275128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easthouse
Glasgow, Lanarkshire
G34 9JE

Discharge Criteria

	Yes	No
Stable vital signs	☒	☐
Alert and Orientated	☒	☐
Pain score is 2 or below	☒	☐
Diet and fluids taken	☒	☐
IV Cannula removed	☒	☐
Received written instructions regarding sedation	☒	☐
Received verbal and written aftercare instructions	☒	☐
Patient Advice Leaflet given (if applicable)	☐	☐

Received Endoscopy Report/ Patient letter Yes ☐ No ☐

If no

Verbal report by endoscopist ☐

Follow up appointment indicated on report Yes ☐ No ☐

Follow up appointment (if given in department)time

Comments.....

I confirm patient is satisfactory for discharge

Print Name M. Kerkwood Signature M. Kerkwood

Discharged at 09:35 to care of Daughter

Irregular discharge Reason

Patients' Signature Nurses Signature

Name of Procedure

Endoscopic Ultrasonography +/- Gastroscopy +/- Dilatation and/or Stent Insertion.

Inspection and ultrasound of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy, needle aspiration, photography). Biopsy samples and images taken will be retained.

Statement of Patient

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in this booklet including the benefits and any risks.

I agree/disagree to any information/images/surplus tissue or other biological material not essential for my diagnosis or future treatment may be used for medical education, audit, and research with ethical approval, to improve the quality of patient care.

Agree ☒ Disagree ☐ (Please tick box)

I agree to the procedure described in this booklet and on the form.

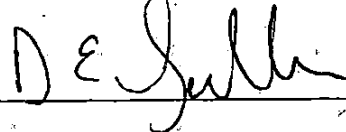
I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will however, have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner.

I agree to have sedation ☒

Have you ever been notified that you are at an increased risk of CJD/VCJD for public health purposes Yes ☐ No ☒

Signed



Date

30/11/2020

Name (print in capitals)

DEBORAH E SULLIVAN

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signed

Date



0712726128

SULLIVAN

Deborah

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

07/12/1972

G34 9JE

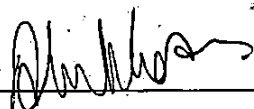
Staff Only

Confirmation of consent (to be completed by a healthcare professional when the patient is admitted for the procedure).

I have confirmed that the patient understands what the procedure involves including any risks.

I have confirmed that the patient has no further questions and wishes the procedure to go ahead.

Signed



Date

5.12.20

Consent Form

It is important that you feel you have all the information that you require about Endoscopic Ultrasonography. Once you are happy that you have enough information about this test you should sign this form to indicate that you consent to undergo the procedure.

If you would like to ask further questions please do not sign the form now. Bring it with you and you can sign it after you have spoken to a member of the healthcare staff.

SULLIVAN, Deborah (Ms)

BORN 07-Dec-1972 (53y) GENDER Female

CHI 0712726128

Orthopaedic Day Case Assessment

Last updated by Najim ATTA (Najim Atta2) 2.5 years ago (v. 2) Show History

Sensitivity

Content Restricted No

Sensitivity

Sensitive

If the information on this form merits further restriction than that of Highly Sensitive, please select health and care providers with the appropriate access permissions

Admission Information

Hospital Glasgow Royal Infirmary

Ward Ward 62

Specialty Physiotherapy

Consultant Miss Nicola Jane Madeley

Theatre date —

Procedure pt admitted for back pain and numbness in both legs, New UI.

16/01/2024: MRI unremarkable

Consent to assessment Yes

Occupation and relevant social history pt has good family support from daughter. lives in ground floor flat, 3 external steps with R sided bannister, nil internal stairs. pt is mainly housebound, shopping is managed online and help with daughter. ADLs managed as home is set up with appropriate equipment. pt has a wet room and walk in shower.

Relevant Medical History Anxiety, depression, fibromyalgia, T2DM - medically controlled, gallstones, lap-chole

Type of Assessment —

Written exercises provided No

Additional comments / advice pt advised on LL strengthening to maintain mobility

Outpatient physiotherapy required No

Physiotherapy discharge Yes

Discharge Summary pt at baseline mobility of x1 e/c on L hand and able to manage stair indep with R sided bannister. nil concerns on scans indicating safe for d/c from ward 62

Walking Aid Issued

Completed by a Student No

PT/OT Initial Interview



Date of Admission: 12/1/17 Ward: 65
 Date of referral: 17/1/17 Hospital: GRI
 Admitted From: HOME EDD: _____
 Consent Obtained for AHP Intervention: Yes ☒ No ☐
 AWI: N/A

Name: 0712726128
 Address: SULLIVAN F
2 Deborah 07/12/1972
6 Muirhead Court
 Age: Baillieston
Glasgow, Lanarkshire
 Chi num: G69 7EP

HPC/Diagnosis: Awoke - a large stroke @ radiate to back. Constant sharp. Unintended food stuff. Post to phobia. Drags @ leg. Fall @ 2 in hospital - under a plank (dry).
 Precautions e.g. diabetic, MRSA, aggressive: Shingles @

Current Investigation / Medical plan: CTB - ve.
LP - await results.
 Relevant Drug History: See kardex

Relevant PMH: Cholelithiasis pancreatitis Fibromyalgia
Cholecystectomy Appendicectomy
Prev. funduscopy Diuretic

AMT / MMSE Score: / Date: /

Sensory Impairment - glasses ☒ hearing aid ☒ speech impairment: Nil
 Comments: Reading

Social History - Obtained from:

Lives alone ☐ Lives with: daughter
 Other social support / Services / Agencies: Nil. Daughter main care.

Accommodation

House ☒ Flat ☐ which floor? _____ Door Entry System Yes ☐ No ☒
 Community Alarm Yes ☐ No ☒

Owner Occupier ☐ Private rental ☒
 Res Care ☐ Nursing home ☐ Housing Ass ☐ Sh. Housing ☐

Stairs

Internal Yes ☒ No ☐

How Many 1 flight

Handrail Yes ☒ No ☐

On the LEFT / RIGHT / BOTH ascending

Stair lift ☐

How Many _____

External Yes ☒ No ☐

Handrail Yes ☐ No ☐

On the LEFT / RIGHT / BOTH ascending

Lift ☐ Ramp ☐

Location of:

Bedroom Upstairs Bathroom Upstairs

Previous Level of Mobility

Previous Mobility - how far can patient walk? Housebound

Indoors (aid?) Nil

Outdoors (aid?) Nil/N/A

Ability to Negotiate Stairs Struggles. Daughter present. Never alone.

Comments: Has had falls on stairs 2 to blackouts

Completed by: P. D'SOUZA Print: SPIN B. NARAYAN Designation: BAND 6 PT. Date: 18/1/17

Completed by: _____ Print: _____ Designation: _____ Date: _____

Patient Name: DEBORAH SULLIVAN CHI: 0712726128

Page Number (2)

Falls History

How many in the last 12 months Frequent falls

Main cause - Trip ☐ Loss of Balance ☐ Blackout ☒ Unknown ☐ Other ☐

Comments:

Warning to falls. Pt stated daughter reports 'It's like you've fallen asleep.'

Previous ADL +/- equipment/assistance in situ

Personal

Washing

Stripwash @ daughter

Domestic

Shopping

Daughter

Toileting

(I)

Laundry

"

Night Toileting

↓

Housework

"

Dressing

(I) @ pyjamas. Doesn't dress

Cooking

Gas ☐

Electric ☐

Microwave ☐

Feeding

(I)

Breakfast

Daughter

Medication

Daughter puts in caps.

Hot drinks

"

Heating

Gas ☐ Electric ☐

Lunch

Daughter

Dinner

Daughter

Driving

Comments:

Daughter & niece assist in personal care and all domestic tasks.

Previous functional transfers +/- equipment in situ

Bed

Roller (I) @ equip

Chair

(I)

Bath

Unable to get in bath.

Shower

Unable to get into bath.

Toilet

(I) @ equip

Commode

N/A

Comments:

Incomplete sections - reasoning

Ongoing plan

AX.

R/N of stairs for Δ.

Patient consent regarding discussion with - Next Of Kin Yes ☐ No ☐

Other Health / Social Care Professionals Yes ☐ No ☐

Completed by

PHYSIO 96

Print

SIRHAN BAKAWI

Designation

BAND 6 PT

Date

18/1/17

Completed by

Print

Designation

Date

AHP INITIAL ASSESSMENT

Patient Name: DEBORAH SULLIVAN

CHI: 0712726128

Page (3)

Consent:

Physical Assessment

Joint	R	L	Muscle Power	R	L
ROM					
UL	Full active	The ROM active - lacks EOR passive 20° (P)	UL	4/5	4/5 + grossly
LL	Full active	Full active	LL	4/5	4/5 + grossly

Additional neurological assessment indicated

Yes / No

Comments:

Bed Mobility Rolling or being moved up or down	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Get to Sit	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Sit to Lie	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Sitting	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Sit to Stand	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ Standard ☐ N/Assessed ☐
Standing If using aid please state type	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐ <u>Nil</u>
Toileting Transfer mode or toilet	Independent ☐ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☒ Aids used:
Mobility State aid used	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐ Gait analysis: <u>Slight to sit seen on @: 6 step length & reduced height. Moderate pace.</u>
Stairs Indicate rails used	Independent ☐ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☒
Wheelchair Users State if indoor/outdoor	Independent ☐ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☒ Additional comments:
Additional Standardised Assessment completed?: Please identify test used & score here:	
Falls risk: High Medium Low	

Signed: [Signature] Print: Simon SMCORU (SR) Designation: Band 6 PT Date: 18/1/17

Signed: _____ Print: _____ Designation: _____ Date: _____

AHP INITIAL ASSESSMENT

Patients Name: DEBORAH SULLIVAN CHI: 0712726128

Page (4)

Potential Is as identified with selfcare? Struggles bath/shower @ home
=> step wash.

Environment: Concerns NIL

Psychologic Status Intact

Processing Skills Intact

Patient and/or Carer concerns

Patient reports - wants to be able to do more.

Problems Identified

- ① ↓ functions
- ② ↓ mob
- ③ Falls

Goals

- ① To ↑ function to ② level of ① & mob & functional tasks
- ② ↑ Pers tolerance around ward
- ③ Minimise risk of falls & advice & mob practice

Treatment Delivered

As only
advised re: exs/activity to minimise pain symptoms
& maintain strength

Analysis

Close to ② baseline, although this is ↓ from ②

Outcome of intervention

Discharged after Initial Assessment? Yes ☐

No ☒

Further PT required ☒

New walking aid issued ☐

Further OT required ☒

Assistive Equipment provided ☐

Ongoing Plan

Cast re-ed
Stair Ax
Equip ^{to} MERS referral

Onward Community referral ☐

Signed: [Signature] 07/10/18
 Signed:

Print: SIMON BAYNE Designation: BAND 6 PT
 Print: Designation:

Date: 18/11/18
 Date:

Page Number _____

NHS
Greater Glasgow
and Clyde

Date of Birth 07/12/72

MIS 243722

Page Number _____

NHS
Greater Glasgow
and Clyde

Date of Birth / /

[illegible]

Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)



Name: .. 0712726128
 Address: SULLIVAN Deborah
 F..... 07/12/1972
 DoB:
 CHI num:

Part 1: Is the patient fit for screening? (Exclude patients on Liverpool Care Pathway or with a tracheostomy tube as these patients are subject to alternative guidelines)

Can the patient:

- Maintain an upright sitting position in a bed or chair **AND**
- Stay awake and alert for 15 minutes while seated upright

Yes – Proceed to Part 2

No

Keep Nil By Mouth and alert medical staff.

- Implement and maintain full oral hygiene.
- Document plan for patient's medication route, hydration and nutritional status.
- **Recommend STOPSS** (new form) when oral feeding is being reconsidered.

Sign: _____ Print: _____
 Grade: _____ Date: _____ Time: _____

Part 2: Does the patient meet any of the criteria below?

Recurrent unexplained chest infections or documented aspiration on formal investigation	☒
Poorly controlled respiration plus new swallowing difficulties	☐
Patient is reporting previously unsuspected swallowing difficulties	☐
Patient has a known swallowing problem (e.g. on a texture modified diet) and is experiencing new difficulties	☐
NB: Exclude vomiting, seizures, oesophageal stricture, reflux disease	

No – Proceed to Part 3

Yes – Alert medical staff. Contact Speech and Language Therapy to discuss referral. (Part 3 **NOT** required)

Sign: _____ Print: _____
 Grade: _____ Date: _____ Time: _____

Part 3: Water Swallow Test

PART A:

Can the patient take 3 x 5ml teaspoons of water **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

Yes

No

1st Attempt – FAIL – Keep nil by mouth and alert medical staff. Repeat Part A within 3-12 hours.

Sign: _____ Print: _____
 Grade: _____ Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and alert medical staff. Contact Speech and Language Therapy to discuss referral.

Sign: _____ Print: _____
 Grade: _____ Date: _____ Time: _____

PART B:

Can the patient drink 50 ml of water from a glass at a comfortable pace **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

Yes - PASS

No

1st Attempt – FAIL – Keep nil by mouth and alert medical staff. Repeat Part B within 3-12 hours.

Sign: _____ Print: _____
 Grade: _____ Date: _____ Time: _____

2nd Attempt – FAIL – Keep nil by mouth and alert medical staff. Contact Speech and Language Therapy to discuss referral.

Sign: _____ Print: _____
 Grade: _____ Date: _____ Time: _____

Commence normal fluids and texture E diet (or pre-admission modified diet).

- If there are no problems over 2 days proceed to previous normal oral intake.
- If problems develop e.g. cough, gurgly voice, moist chest or chest infection consider a nil by mouth regime, alert medical staff and contact Speech and Language Therapy to discuss.

Sign: *ABen* Print: *ABen* Grade: *S/N* Date: *18/1/17* Time: *1300*

PT/OT Initial Interview



Date of Admission: 12/1/17 Ward: 65
 Date of referral: 17/1/17 Hospital: GRI
 Admitted From: HOME EDD: _____
 Consent Obtained for AHP Intervention: Yes ☒ No ☐
 AWI: N/A

Name: 0712726128
 Address: SULLIVAN F
2 Deborah 07/12/1972
6 Muirhead Court
 Age: Baillieston
Glasgow, Lanarkshire
 Chi num: G69 7EP

HPC/ Diagnosis: Awoke & aggressive @ radiate to back. Constant sharp. Vomited food stuff. Postoperative. Drags @ leg. Fall x 2 in hospital - under a plank (dry).
 Precautions e.g. diabetic, MRSA, aggressive: Shingles @

Current investigation/ Medical plan: CTB - ve.
LP - await results.
 Relevant Drug History: See Kardex

Relevant PMH: Gallstones pancreatitis Fibromyalgia Cholecystectomy Appendicectomy Prev. Funduscopy
Prenatal patches Pregabalin Dihydrocodeine Difenhydramine

AMT / MMSE Score: 1 Date: 17/1/17

Sensory Impairment - glasses: ☒ hearing aid: ☒ speech impairment: Nil
 Comments: Reading

Social History - Obtained from:
 Lives alone ☐ Lives with: daughter
 Other social support / Services / Agencies: Nil. Daughter main care.

Accommodation
 House ☒ Flat ☐ which floor? _____ Door Entry System Yes ☐ No ☒
 Community Alarm Yes ☐ No ☒
 Owner Occupier ☐ Private rental ☒
 Res Care ☐ Nursing home ☐ Housing Ass ☐ Sh Housing ☐
 Stairs
 Internal Yes ☒ No ☐ How Many 1 flight
 Handrail Yes ☒ No ☐ On the LEFT / RIGHT / BOTH ascending
 Stair lift ☐ _____
 External Yes ☒ No ☐ How Many _____
 Handrail Yes ☐ No ☐ On the LEFT / RIGHT / BOTH ascending
 Lift ☐ _____ Ramp ☐ _____
Housebound

Location of:
 Bedroom Upstairs Bathroom Upstairs

Previous Level of Mobility
 Previous Mobility - how far can patient walk? Housebound
 Indoors (aid?) Nil Outdoors (aid?) Nil/N/A
 Ability to Negotiate Stairs Struggles. Daughter present. Never alone.
 Comments: Has had falls on stairs 2" to blackouts

Completed by: P. Dittus BSc Print SIMON PRINCE Designation BAND 6 PT. Date 18/1/17
 Completed by: _____ Print _____ Designation _____ Date _____

Patient Name: DEBRAH SULLIVAN CHI: 0712726128

Page Number 2

Falls History

How many in the last 12 months Frequent falls

Main cause - Trip ☐ Loss of Balance ☐ Blackout ☒ Unknown ☐ Other ☐

Comments:

Warning to falls. Pt stated daughter reports 'it's like you've fallen asleep.'

Previous ADL +/- equipment/assistance in situ

Personal

Washing

Stripwash @ daughter

Domestic

Shopping

Daughter

Toileting

(I)

Laundry

"

Night Toileting

↓

Housework

"

Dressing

(I) @ pyjamas. Doesn't dress

Cooking

Gas ☐

Electric ☐

Microwave ☐

Feeding

(I)

Breakfast

Daughter

Medication

Daughter puts in caps.

Hot drinks

"

Heating

Gas ☐ Electric ☐

Lunch

Daughter

Dinner

Daughter

Driving

Comments:

Daughter & niece assist in personal care and all domestic tasks.

Previous functional transfers +/- equipment in situ

Bed

Roller (I) @ equip

Chair

(I)

Bath

Unable to get in bath.

Shower

Unable to get in to bath.

Toilet

(I) @ equip

Commode

N/A

Comments:

Incomplete sections - reasoning

Ongoing plan

AK.

Rev of stairs for A.

Patient consent regarding discussion with - Next Of Kin Yes ☐ No ☐

Other Health / Social Care Professionals Yes ☐ No ☐

Completed by

PHYSIO BG

Print

SIRHAN BANCOWITZ

Designation

BAND 6 PT

Date

18/1/17

Completed by

Print

Designation

Date

AHP INITIAL ASSESSMENT

Patient Name: DEBORAH SULLIVAN

CHI: 0712726128

Page (3)

Consent:

Physical Assessment

Joint	R	L	Muscle Power	R	L
RoM					
UL	Full active	3/4 ROM active - lacks EOR passive 20% (P)	UL	G IV	G IV + grossly
LL	Full active	Full active	LL	G IV	G IV + grossly

Additional neurological assessment indicated

Yes / (NO)

Comments:

Bed Mobility Rolling or being moved up side	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
lie to Sit	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Sit to Lie	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Sitting	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐
Sit to Stand	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ Standard ☐ N/Assessed ☐
Standing If using aid please state type	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐ <u>nd</u>
Toileting Transfer mode or toilet	Independent ☐ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☒ Aids used:
Mobility State aid used	Independent ☒ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☐ Gait analysis: <u>Short & it seen on (C) 1 step length & reduced height. Moderate pace.</u>
Stairs Indicate rails used	Independent ☐ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☒
Wheelchair Users State if indoor/outdoor	Independent ☐ Supervision ☐ Assist of 1 ☐ Assist of 2 ☐ N/Assessed ☒ Additional comments:
Additional Standardised Assessment completed?: Please identify test used & score here:	
Falls risk: High Medium Low	

Signed: [Signature] Print: Simon Samson (SR) Designation: Band 6 PT Date: 18/1/17

Signed: _____ Print: _____ Designation: _____ Date: _____

AHP INITIAL ASSESSMENT

Patients Name: DEBORAH SULLIVAN CHI: 0712726128

Page (4)

Potential Is = as identified with selfcare?: Struggles bath/shower @ home
=> step wash.

Environmental Concerns Nil.

Psychological Status Intact

Processing Skills Intact

Patient and/or Carer concerns

Patient reports wants to be able to do more.

Problems identified

- ① ↓ function
- ② ↓ mob
- ③ Falls.

Goals

- ① To ↑ function to ② level of ① in mob & functional tasks
- ② ↑ tolerance around word
- ③ Minimise risk of falls & advice & mob practice

Treatment Delivered

As only
advised re: ex/actvity to minimise pain symptoms
& maintain strength

Analysis

Close to ② baseline, although this is ↓ from ②

Outcome of intervention

Discharged after Initial Assessment? Yes ☐

No ☒

Further PT required ☒

Further OT required ☒

New walking aid issued ☐

Ongoing Plan

Cost re-ed
Stair Aid
Equip^{ts} & ADERS referral.

Assistive Equipment provided ☐

Onward Community referral ☐

Signed: [Signature] PHYSIO
 Signed:

Print: SIMON BAYNE Designation: PHYSIO PT
 Print: Designation:

Date: 12/11/19
 Date:

Page Number _____

NHS
Greater Glasgow
and Clyde

Date of Birth 07/12/72

Date/Time	PT/OT/Support Worker	Continuation Notes & Progress Record	Signature & Designation
19/1/17 13 ³⁰ hrs	PT/OT/ AP	⑤ PT lying on bed, % pain in back 2nd to CP over 1/2 ago. Reports had a shower this morning ⑤ Consented to - put ⑥ Tx: - Lie → sit → stand: safe + ⑤ - Donning shoes/slippers - ⑤. Required verbal prompts to use ⑤ UL Mobs: - mob = "and ~ 20m // no assist reg'd. Discrete supervision only. Mild to wt bearing on ⑤ CL but ⑤ mob. Stairs: - ascended to 1 rail + step - to pattern // safe + ⑤ - descended to 1 rail + both hands, sideways // safe + ⑤ ⑦ Pt at a safe level for ⑤ home when medically fit. Will arrange OT follow-up + community for home care. Advised on activity and midfulness + encouraged more ⑤ activities + @ home + daughter's supervision only ⑧ D/C from PT/OT. OT follow-up on ⑤.	
		PT/OT: RL SARAH BONCOURT (SB)	

Page Number _____

NHS
Greater Glasgow
and Clyde

Date of Birth mm/dd/yyyy ____/____/____

[illegible]

Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)



Name: ..	0712726128	
Address: SULLIVAN	Deborah	F.....
DoB:	07/12/1972	
CHI num:		

Part 1: Is the patient fit for screening? (Exclude patients on Liverpool Care Pathway or with a tracheostomy tube as these patients are subject to alternative guidelines)

Can the patient:

- Maintain an upright sitting position in a bed or chair **AND**
- Stay awake and alert for 15 minutes while seated upright

Yes - Proceed to Part 2

No

Keep Nil By Mouth and alert medical staff.

- Implement and maintain full oral hygiene.
- Document plan for patient's medication route, hydration and nutritional status.
- **Recommend STOPSS** (new form) when oral feeding is being reconsidered.

Sign: _____ Print: _____
Grade: _____ Date: _____ Time: _____

Part 2: Does the patient meet any of the criteria below?

Recurrent unexplained chest infections or documented aspiration on formal investigation	
Poorly controlled respiration plus new swallowing difficulties	
Patient is reporting previously unsuspected swallowing difficulties	
Patient has a known swallowing problem (e.g. on a texture modified diet) and is experiencing new difficulties	
NB: Exclude vomiting, seizures, oesophageal stricture, reflux disease	

No - Proceed to Part 3

Yes - Alert medical staff. Contact Speech and Language Therapy to discuss referral. (Part 3 **NOT** required)

Sign: _____ Print: _____
Grade: _____ Date: _____ Time: _____

Part 3: Water Swallow Test

PART A:

Can the patient take 3 x 5ml teaspoons of water **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

Yes

No

1st Attempt - FAIL - Keep nil by mouth and alert medical staff. Repeat Part A within 3-12 hours.

Sign: _____ Print: _____
Grade: _____ Date: _____ Time: _____

2nd Attempt - FAIL - Keep nil by mouth and alert medical staff. Contact Speech and Language Therapy to discuss referral.

Sign: _____ Print: _____
Grade: _____ Date: _____ Time: _____

PART B:

Can the patient drink 50 ml of water from a glass at a comfortable pace **WITHOUT** coughing **OR** choking **OR** becoming breathless **OR** hoarse **OR** gurgly?

Yes - PASS

No

1st Attempt - FAIL - Keep nil by mouth and alert medical staff. Repeat Part B within 3-12 hours.

Sign: _____ Print: _____
Grade: _____ Date: _____ Time: _____

2nd Attempt - FAIL - Keep nil by mouth and alert medical staff. Contact Speech and Language Therapy to discuss referral.

Sign: _____ Print: _____
Grade: _____ Date: _____ Time: _____

Commence normal fluids and texture E diet (or pre-admission modified diet).

- If there are no problems over 2 days proceed to previous normal oral intake.
- If problems develop e.g. cough, gurgly voice, moist chest or chest infection consider a nil by mouth regime, **alert medical staff** and contact Speech and Language Therapy to discuss.

Sign: *ABE* Print: *ABE* Grade: *S/N* Date: *18/1/17* Time: *1300*

Patient name

0712726128

SULLIVAN

F

Patient Care

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE



Emergency Care Nursing Documentation

Initial Investigations						Communication			
Initial when complete	Required?	Init		Required?	Init	Required?			
Patient prepared for exam	☒	N	☒	Pain score	Y	N	GGC Red Bag with Patient (nursing home resident)	Y	N
NEWS/MEWS/PEWS chart	☒	N	☒	Peak flow	Y	N	Language or hearing difficulty	Y	N
ID Band	☒	N		MSSU Results:			Interpreter required	Y	N
12-Lead ECG	☒	N					what arrangements have been made?		
Blood samples	☒	N					Relatives / Carer / Next of Kin present	Y	N
Blood Gas	Y	N					name, relationship, location, particular concerns		
Viral Swab	Y	N		B-HCG	+ve	-ve	Signature:		

PVC		Diagnostic Resuscitation Intravenous Fluids Transfusion	Insertion	Insertion Side:	L	R	Size of PVC:	Inserted by																																																																								
Circle reason:	D R I F T		Date: _____ Time: _____	Insertion Site:				Signature																																																																								
Hand Hygiene	Yes ☐	Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol	Yes ☐	Sterile transparent semi-permeable dressing affixed	Yes ☐	PVC Reason Explained	Yes ☐																																																																									
<table border="1"> <thead> <tr> <th colspan="4">Risk Assessments and Screening Tools</th> <th>Required?</th> <th>Init</th> <th colspan="4"></th> <th>Required?</th> <th>Init</th> </tr> </thead> <tbody> <tr> <td colspan="4">SEPSIS</td> <td>Y</td> <td>N</td> <td colspan="4">GMAWS</td> <td>Y</td> <td>N</td> </tr> <tr> <td>FAST +VE</td> <td>Y</td> <td>N</td> <td>STOPPS</td> <td>Y</td> <td>N</td> <td colspan="4">Public Protection Concern (Adult/Child)</td> <td>Y</td> <td>N</td> </tr> <tr> <td colspan="4">ED Falls Risk Assessment</td> <td>Y</td> <td>N</td> <td colspan="4">Notification of Concern Completed (NOC)</td> <td>Y</td> <td>N</td> </tr> <tr> <td colspan="4">Mental Health Triage Assessment</td> <td>Y</td> <td>N</td> <td colspan="4">Frailty Assessment Completed</td> <td>Y</td> <td>N</td> </tr> <tr> <td colspan="4">Ligature low room</td> <td>Y</td> <td>N</td> <td colspan="4">4AT Assessment</td> <td>Y</td> <td>N</td> </tr> </tbody> </table>									Risk Assessments and Screening Tools				Required?	Init					Required?	Init	SEPSIS				Y	N	GMAWS				Y	N	FAST +VE	Y	N	STOPPS	Y	N	Public Protection Concern (Adult/Child)				Y	N	ED Falls Risk Assessment				Y	N	Notification of Concern Completed (NOC)				Y	N	Mental Health Triage Assessment				Y	N	Frailty Assessment Completed				Y	N	Ligature low room				Y	N	4AT Assessment				Y	N
Risk Assessments and Screening Tools				Required?	Init					Required?	Init																																																																					
SEPSIS				Y	N	GMAWS				Y	N																																																																					
FAST +VE	Y	N	STOPPS	Y	N	Public Protection Concern (Adult/Child)				Y	N																																																																					
ED Falls Risk Assessment				Y	N	Notification of Concern Completed (NOC)				Y	N																																																																					
Mental Health Triage Assessment				Y	N	Frailty Assessment Completed				Y	N																																																																					
Ligature low room				Y	N	4AT Assessment				Y	N																																																																					

Pause for Discharge			Pause for Transfer		
GGC Red Bag with Patient (nursing home resident)	Y	N	GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N	Relatives / Carer with Patient	Y	N
Name Band Removed	Y	N	Name Band in situ	Y	N
Risk Assessment/Screening Tools Completed	Y	N	Risk Assessment/Screening Tools Complete	Y	N
Discharge Information	Y	N	Bed Available	Y	N
NEWS Chart completed within 1 hour of discharge	Y	N	SBAR complete	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N	NEWS Chart completed within 1 hour of transfer	Y	N
Notes Complete	Y	N	Medications/Fluids prescribed as per medication prescription form	Y	N
Belongings	Y	N	PVC/CVC Bundle	Y	N
Transport arranged	Y	N	Notes Complete	Y	N
Own/Taxi/Relative/SAS (Please circle)	Y	N	Belongings	Y	N
PVC Removed Prior to Discharge	Y	N	Escort Required	Y	N
Signature:			Signature:		

Patient

Patient

0712726128
SULLIVAN
Deborah
07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr 4hr

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times																
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.																
	2	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If yes inform registered nurse/ Review analgesia																
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU - Pressure Ulcer INT = Intact M = Moisture																
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand																
		ELIMINATION Does the patient need the toilet?																
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)																
N	6	FOOD FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplements taken? Has oral hygiene been carried out as per care plan?																
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?																
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return																
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return																
		Care provider																
		Role																

Ask the patient if there is anything they specifically want done today:

Pati 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital:

Ward:

Points to consider:

- Use within 8 hrs of admission to care area
- Re-assess daily and more frequently if a person's condition changes

NHS
Greater Glasgow
and Clyde

Attach addressograph	Hospital:	Points to consider:
	Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

Pressure damage	NO RISK	At RISK	Grade 1 - non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD)	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing
	↓	↓	↓	↓
I MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

1 Pressure Damage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2 Mobility	Does the person require assistance to mobilise or change position?
3 Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.

If you have answered YES to any of the questions above, please complete the SSKINS care plan below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	SKIN INSPECTION	SURFACE	KEEP MOVING	INCREASED MOISTURE AND CONTINENCE MANAGEMENT	NUTRITION	SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other: ☐	Specify: • Mattress: ☐ • Cushion: ☐ • Detail additional pressure redistributing equipment: ☐ Off loading boot: ☐ Protective product: ☐	• Reposition _____ hourly in bed. • Reposition _____ hourly in chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used: ☐ Tilting device ☐ Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family / carer needs: • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

[illegible]

Patient n:

Patient C:



0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

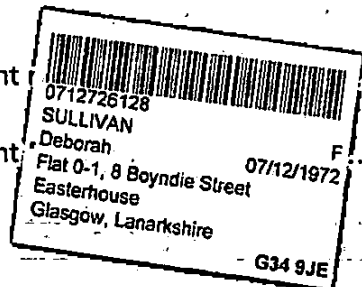


Greater Glasgow
and Clyde

Use the following Codes: Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent										
Ongoing Care										
	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours	
Time										
Nursing notes updated including (NEWS, MEWS, PEWS)										
Food, Fluid, Nutrition (provide details)										
IVI/IVABs										
Routine Medications prescribed and administered										
Falls risk assessment reviewed/checklist										
Skin assessed and supported (PURDRA)										
Pain assessment										
SBAR up to date and completed										
Patient/ relatives updated										
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter										
STOPPS completed										
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?										Commence CVC/PVC chart

Patient

Patient

Greater Glasgow
and Clyde

Nursing notes

Date and Time		Name/Signature
5/12/28 1600	Pt. brought to hospital w/ chest/abdo pain. In corridor awaiting boards/ECG.	J. McS/N
1710	Anti emetic. for analgesia once nausea settles	J. McS/N
2120	Pt brought into cubical. Changed into gown. Await medical Rlv.	S. Walker JN J. McS/N
2225	Observations as checked - NEWS 2 S/O medical staff and bloods taken. All already in place so pt presented and sent to get ondansetron & morphine and IV fluids	J. McS/N
2245	morphine given orally and ondansetron given as per kardex	J. McS/N
0300	Pt settled after IV morphine. A/W ward bed	J. McS/N

NEXT OF KIN DETAILS:

Name: Robert
Glass

Relation: Partner

Contact number:

07597389233

W: 86.8

H: 59

L: 175cm

MAR PART 1:

PREFERRED NAME: Debbie

COGNITIVE STATUS: 0

WHO IS IMPORTANT TO YOU: Partner, Daughter

Do you have an informal carer?

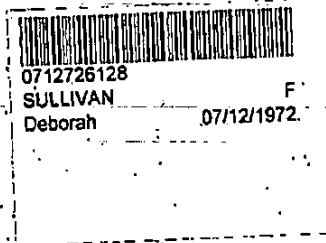
COMMUNICATION AND SENSES:

Preferred Language? English Interpreter required? N

Glasses? Y Reading Distance/Both with ph. Contacts? N

Hearing aids? Yes No With patient on admission? Yes No

Cochlear Implant? Yes No



HEALTH PROFILE:

Smoking Status: Smoker Ex-Smoker E.Cigarette Vape - occasionally

How many daily? When did you stop?

Any recreational drug use? N

Any Alcohol intake? N How many units? How Often?

Any previous withdrawal?

POWER OF ATTORNEY OR GUARDIANSHIP:

Who? N

HOME CIRCUMSTANCES:

Who stays at home? Alone

Any Dependents? N

Any social care or social services input? N

EMPLOYMENT STATUS:

Employed Unemployed Self-Employed Retired Full-time education

MAR PART 2:

PRESENTING COMPLAINT: AP+ N

PAST MEDICAL HISTORY:

T2DM HTN, chronic pancreatitis, fibromyalgia, cholecystectomy,
Insulin OGD-delayed gastric emptying

DO YOU HAVE A DNACPR: N

ANY BREATHING OR CIRCULATORY PROBLEMS? N

(Inhalers/home oxygen/nebulisers/ high blood pressure/AF/pacemaker/cough/angina?)

DO YOU HAVE NEW PAIN? *N*

DO YOU SUFFER FROM ANY AREAS OF CHRONIC PAIN? *Y*

HYDRATION AND NUTRITION:

Allergies/intolerances: *Penicillin* Likes _____ Dislikes _____

Any special diet? *N*

Enteral/parenteral nutrition regime? *N*

Do you require assistance with eating? *N*

Any swallow issues? *N*

ELIMINATION NEEDS:

Continent? *Y*

Incontinent? _____

Stoma? _____

Catheter? _____

What assistance do you need? _____

*everyday
BO-yet*

Bedrails at night

PERSONAL CARE NEEDS:

(1)

*P.V.C (1) forearm
line*

BH = 8

GENERAL HEALTH:

DENTAL WORK:

Do you wear dentures? Top/Bottom *N*

Are they a good fit? Yes No

Are this with you on admission? Yes No

SKIN CARE:

intact

WOUNDS:

NO

MOBILITY STATUS:

Mobility Aid:

stick around house

Any recent Falls:

Y shower 2 months ago

SLEEP AND REST:

Y Diazepam bed time

EMOTIONAL AND SPIRITUAL CARE:

Do you follow any religion? *N*

How does that impact your care? *N*

4AT?

WEIGHT:

HEIGHT:

WEIGHT LOSS?:

Y

INFECTION CONTROL:

Any recent contact in last 14 days with any infections such as Covid/Flu/chickenpox/mumps? *N*

CPE? Any hospital admissions outwith Scotland in the last 12 months? *N*

Have you been previously tested for CPE?

Have you ever been informed you are at risk of CJD or vCJD? *N*

Have you previously been told you have VRE? *N*

MRSA? Have you been admitted from a nursing home? Or previously had MRSA? *N*

0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Patient Address Label



0712726128
SULLIVAN
Deborah

07/12/1972

	Date of Next assessment	Date of Next assessment	Date of Next assessment	Date of Next assessment
Risk Assessments (and when to update)				
PUDRA (within 8 hrs of admission and daily)	13/2/26			
	Daily			
MUST (within first 24 hrs, on transfer to new ward, weekly)	13/2/26			
Falls Risk Assessment (within 24 hrs; post fall, weekly)	13/2/28			
Bed Rails Assessment (within 24 hrs, post fall, if change to condition, weekly)	13/2/26			
Moving and Handling (within 24 hrs and weekly)	13/2/26			
4AT - If over 65 or cognitive impairment (within 24 hrs, fluctuation in condition, weekly)	N/A			
Care Plan (Daily)				
Discharge Checklist (Initiate on admission and complete on discharge)				
Name and signature	Holmes Cregan			
Date	6/2/26			

0712726128
 SULLIVAN
 Deborah 07/12/1972 F
 Flat 0-1, 8 Boydrie Street
 Easterhouse
 Glasgow, Lanarkshire
 G34 9JE

Preferred Name	Debbie
Age	53
Consultant	Mr Roxburgh
DNACPR?	
AWI?	NO
NOK Details	Robert Glass - Partner 07597389233
Urinalysis	☐
Presenting Complaint	AP+ N
Allergies	Penicillin
PMH	T2DM - insulin, HTN, chronic pancreatitis, fibromyalgia, cholecystectomy, OGD - delayed gastric emptying.
Height & Weight	W: 86.8 Kg H: 5'9
Immun	MRD

Date: 12/2/26

1. Signed [Signature] Name Hayley Finn Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

G34 9JE

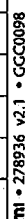
Feeling better

NHS
Greater Glasgow
and Clyde

[illegible]

225

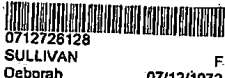
Ward:



N.B. Record what and to whom escalated.

[illegible]

Fluid Balance Chart

 0712726128 SULLIVAN Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE © 1999 NHS Forth Valley Health Board. All rights reserved. NHS Forth Valley Health Board is a registered charity.	Hospital: <u>GR1</u> Ward: <u>65</u> Date: <u>12/02/26</u>	Reason for Fluid Balance Chart _____ Is patient fluid restricted? Yes ☐ No ☐ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: _____ Designation: _____
	ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT		

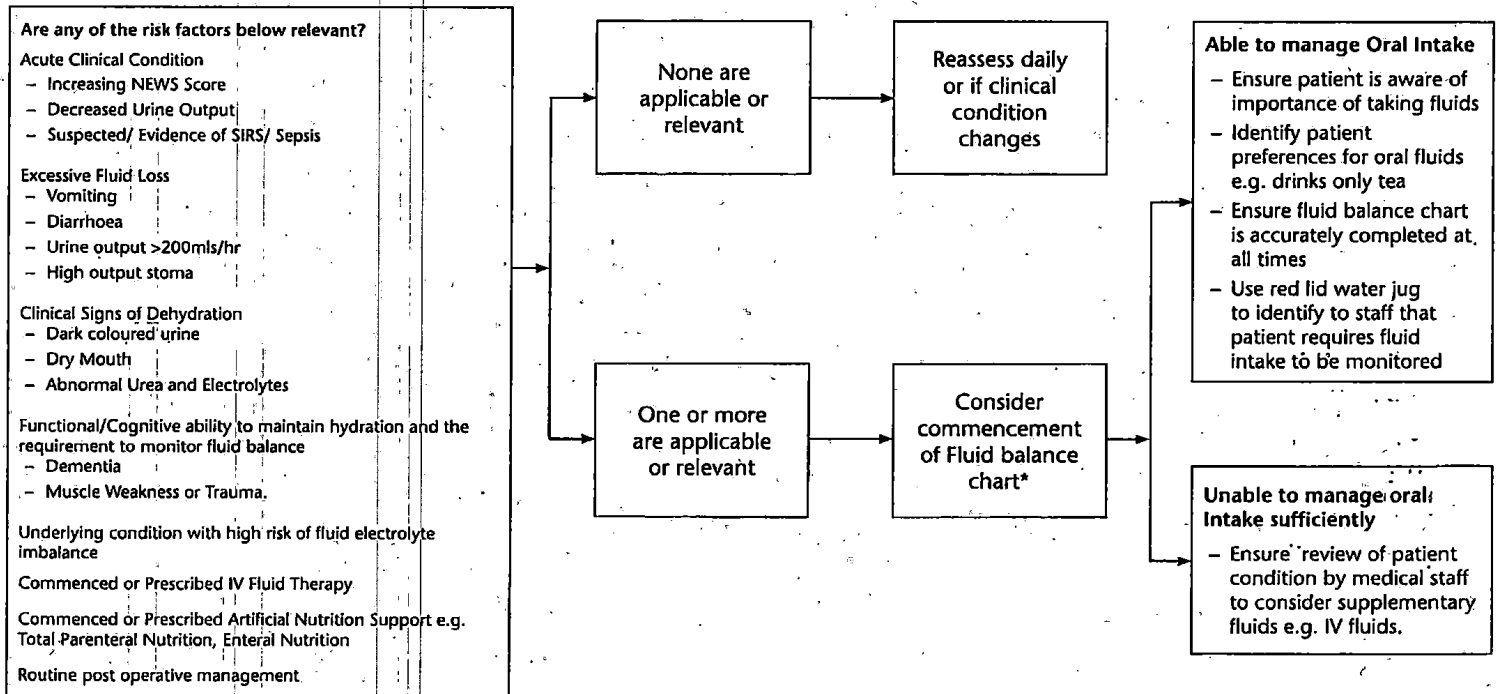
Time	Input								Running Total INPUT	Output			Type	Type	Type	Running Total OUTPUT	Initials	
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel						
	Type	Volume	Type	Volume	Type	Volume	Type	Volume										
00:00										100								
01:00																		
02:00										200								
03:00										100								
04:00																		
05:00																		
06:00																		
07:00	TEA	200								300						600		
08:00																		
09:00	WATER	375																
10:00																		
11:00	TEA	200							775									
12:00	SUP	150																
13:00	MILK	150																
14:00	TEA	200																
15:00																		
16:00	WATER	75																
17:00																		
18:00																		
19:00																		
20:00																		
21:00																		
22:00																		
23:00																		
*Total Intake											*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid
Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

Date: 11/02/20

1. Signed EM Name E. McGrilven Designation SN
2. Signed H. Finn Name Hayley Finn Designation SN
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

0712726128
SULLIVAN
Deborah
07/12/197
Flat 0-1, 8 Boydnie Street
Easterhouse
Glasgow, Lanarkshire
G34 9J

07/12/1972 Greater Glasgow
and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

No thanks

		Times		01 03 05 09		12 00 02 04 06 08 10 11 01 03 05 07 09 11 01 03 05 07 09 11	
	1. THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N
	2. PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N
5	3. SKIN INSPECTION Pressure areas checked:	N	N	N	N	N	N
	Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I	I	I	I	I
K	4. KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y
	Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	B	B	B	R	R
	Chair Assist to walk or stand (W/ST)	Y	Y	Y	Y	Y	Y
I	5. ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I
N	6. FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	Y	Y	N	N	N
	Drink taken?	N	N	N	N	Y	Y
	Food, snack, or supplement taken?	N	N	N	N	Y	Y
	Has oral hygiene been carried out as per care plan?	N	N	N	N	Y	Y
	7. ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y
	8. INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N
	9. ESCALATION Escalate any issues to the registered nurse and document overleaf.	N	N	N	N	N	N
	Care provider / role	OK	OK	OK	OK	OK	OK

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Write or affix label N. 0712725128 A. SULLIVAN CI Deborah D. 07/12/1972 H. F		Peripheral Venous Cannula (PVC) Insertion & maintenance Please complete insertion details for each PVC inserted Care & maintenance to be undertaken & documentation completed twice each day.	Modified Visual Infusion Phlebitis (VIP) Score <table border="1"> <tr> <td>PVC site appears healthy</td> <td>0</td> <td>No phlebitis: Continue care and maintenance</td> </tr> <tr> <td>Either slight pain or redness near site</td> <td>1</td> <td>Possible first signs: Observe PVC site</td> </tr> <tr> <td>Two or more: pain / redness / swelling</td> <td>2</td> <td>Early stage of phlebitis: Remove and resite PVC</td> </tr> <tr> <td>All: pain / redness / hardening of surrounding area</td> <td>3</td> <td>Phlebitis/thrombophlebitis: Remove and resite PVC</td> </tr> <tr> <td>As above and including: palpable venous cord</td> <td>4</td> <td>Seek further advice</td> </tr> <tr> <td>As above and including: pyrexia</td> <td>5</td> <td></td> </tr> </table>	PVC site appears healthy	0	No phlebitis: Continue care and maintenance	Either slight pain or redness near site	1	Possible first signs: Observe PVC site	Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC	All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC	As above and including: palpable venous cord	4	Seek further advice	As above and including: pyrexia	5	
PVC site appears healthy	0	No phlebitis: Continue care and maintenance																			
Either slight pain or redness near site	1	Possible first signs: Observe PVC site																			
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC																			
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC																			
As above and including: palpable venous cord	4	Seek further advice																			
As above and including: pyrexia	5																				

Insertion details: Date: 6/2/26 (Day 1) Time:	Where inserted: ☒ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown	Insertion site: ☐ Hand ☐ Arm Other: Forearm	Side: ☒ Left ☐ Right	Size of cannula: ☐ 26G Purple ☐ 24G Yellow ☒ 23G Blue ☐ 20G Pink ☐ 18G Green ☐ 16G Grey ☐ 14G Orange	Inserted by: Print: Deborah Signature: Designation:
Clinical indication: ☒ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion	
Insertion criteria: ☒ Hand hygiene performed ☐ Yes ☐ No	☐ Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	☐ Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	☐ PVC explained to patient/carer ☐ Yes ☐ No		

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.		Signs of local or systemic infection	
Justify the need for your patient to have a PVC using the DRIFT mnemonic. ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest? ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route? ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?		Local Infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines IV → Oral Antibiotic Switch Therapy (IVOST) Guideline	
Review need for IV antibiotics daily Can antibiotic therapy be stopped? (eg: alternative diagnosis)? If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours Switch to oral when: a CLINICAL IMPROVEMENT in signs of infection eg: temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption) a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureus bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess. DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness Record the stop date on HEPMA If IVOST criteria met → Switch to oral Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures IF not responsive MICROBIOLOGY switch to oral as outlined below	

PVCs should be removed as soon as no longer clinically indicated.

Write or affix label

Name:
Address:
CHI:
DOB:
Hospital & Ward:

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 6/2/26	☒ Yes ☐ No	☒ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day <u>C. Ryan</u> Night <u>D. Lindsay</u>
Day 2 7/2/26	☐ Yes ☐ No	☒ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day <u>M. O'Connell</u> Night <u>M. O'Connell</u>
Day 3 8/2/26	☒ Yes ☐ No	☒ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☒ Left in situ ☐ Redressed ☐ Removed	Day <u>P. O'Connell</u> Night <u>P. O'Connell</u>
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5 10/2	☒ Yes ☐ No	☐ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u>P. O'Connell</u> Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u>0</u>	VIP <u>0</u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed 11/2/26

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:
--------------------	---	---------------------------------------	--	---	--------

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1
Target >96%

Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

SpO2 Scale 2
Target 88-92%

Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

Patient on home oxygen Y ☐ N ☐
If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed: _____

Medical: _____

Date: _____

Glasgow Coma Scale

Eye	Verbal	Motor	Total
4	5	6	15
3	4	5	12
2	3	4	9
1	2	3	6
0	1	2	3
0	0	1	1
0	0	0	0

Pupil Reaction and Size

• = sluggish
• = no reaction
• = eyes closed

Pupil Size (mm)

1 2 3 4 5 6 7 8

Affix Patient ID

Pain Function Score

A No limitations, activity unrestricted by pain or senses quickly
B Mild limitations, mild activity restrictions
C Moderate limitations, attempts but reluctant to continue because of pain, seek advice
D Severe limitations, unable to or refuse to perform because of pain, urgent review required

Pain Score

Ask the patient to rate their pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain	Moderate Pain	Severe Pain
0	1	2	3
4	5	6	7
8	9	10	

NEWS2 Key	1	2	3
-----------	---	---	---

[illegible]

A + B		Respirations		Breaths/min	
225	3				
21-24	2				
12-20	0				
5-11	1				
5B	3				

[illegible][illegible][illegible]

C

Blood Pressure mmHg

(Score uses systolic BP only)

Day	Group A (mmHg)	Group B (mmHg)
0	115	115
20	115	110
40	115	105
60	115	100
80	115	95
100	115	90
120	115	85
140	115	80
160	115	75
180	115	70
200	115	65

C		Pulse		Beats / min	
121-130	3				
111-120	2				
101-110	1				
91-100	1				
81-90	0				
71-80	0				
61-70	0				
51-60	0				
41-50	1				
31-40	3				
21-30	3				

[illegible]

E		Temperature	
		23.0	1
		24.1-25.0	1
		27.1-28.0	0
		28.1-29.0	0
		29.1-30.0	1
		31.0	3

[illegible]

Blood glucose	7.0	/	/
Pain / function score	QA	% ₁₀	/
Time Pt last passed urine	10.20	P _U	P _H
Fluid balance chart indicated Y/N	N	Y	Y
GCS indicated Y/N	N	N	N
Time NEWS due	23.00	13 SO	19 16
Escalation of care Y/N	N	N	N
Miles	AS	//	CN

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation $\geq 94\%$ (COPD $88-92\%$)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE	
A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature: _____	Signature: _____	If yes, add details of oxygen therapy
Print Name: _____	Print Name: _____	
Dr/ANP Initials ONLY: _____	Dr/ANP Initials ONLY: _____	
Date: _____	Date: _____	

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations.

Signed _____

Medical:_____

Date: _____

[illegible]

[illegible][illegible]

A + B	97		07986				96A99				96AF96	296	0	969896	96979696	9696		96	9699
SpO2 Scale 1	94											94-93	1	94			94	95	
Oxygen saturation (%)												92-93	2						
												591	3						

[illegible][illegible][illegible]

C		Pulse		Beats / min	
121	3				
121-130	2				
111-120	2				
101-110	1				
91-100	1				
81-90	0				
71-80	0				
61-70	0				
51-60	0				
41-50	1				
31-40	3				

D Any changes in neuro response, do GCS, immediate medical review. Check Blood Glucose. Think Dementia.	0 0 2 1 0 0 0 A P 1 A A A A										A Alert		0 0 A A A A A 0 J A										0 0	
											C Row Confusion												3	
											V Verbal												3	
											P Pressure												3	

E		Temperature		Chung chung		3	
				230	2		
				28.1-29.0	1		
				27.1-28.0	0		
				26.1-27.0	0		
				25.1-26.0	1		
				24.5.0	2		

NEWS Total	0	2	1	1	1	3	3	5	2	1	1	2	1	2	0	1	0	9	0	0	1	2	1	3	0	0	3
------------	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

[illegible]

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation $\geq 94\%$ (COPD $\geq 92\%$)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE:	
A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.	
C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.	
E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.	

07/12/2012	07/12/18
SULLIVAN	
Deborah	
Flat 0-1, 8 Boydnie Street	
Eastlehouse	
Glasgow, Lanarkshire	
	G34 9

Abbreviations for recording oxygen device	
A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser

RM	Reservoir Mask (Emergency use only)
----	--

0712218728
SULLIVAN
Deborah
Flat 0-1, 8 Boyndle Street
Eastenhouse
Glasgow, Lanarkshire
G34 5JF

Fluid Balance Chart

Nar 0712726128 DoI SULLIVAN Deborah Chi Affix	Hospital: <u>GRI</u> Ward: <u>OS</u> Date: <u>11/02/26</u>	Reason for Fluid Balance Chart: <u>MONITOR</u> Is patient fluid restricted? Yes ☐ No ☒ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☒ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: _____ Designation: _____
	ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT		

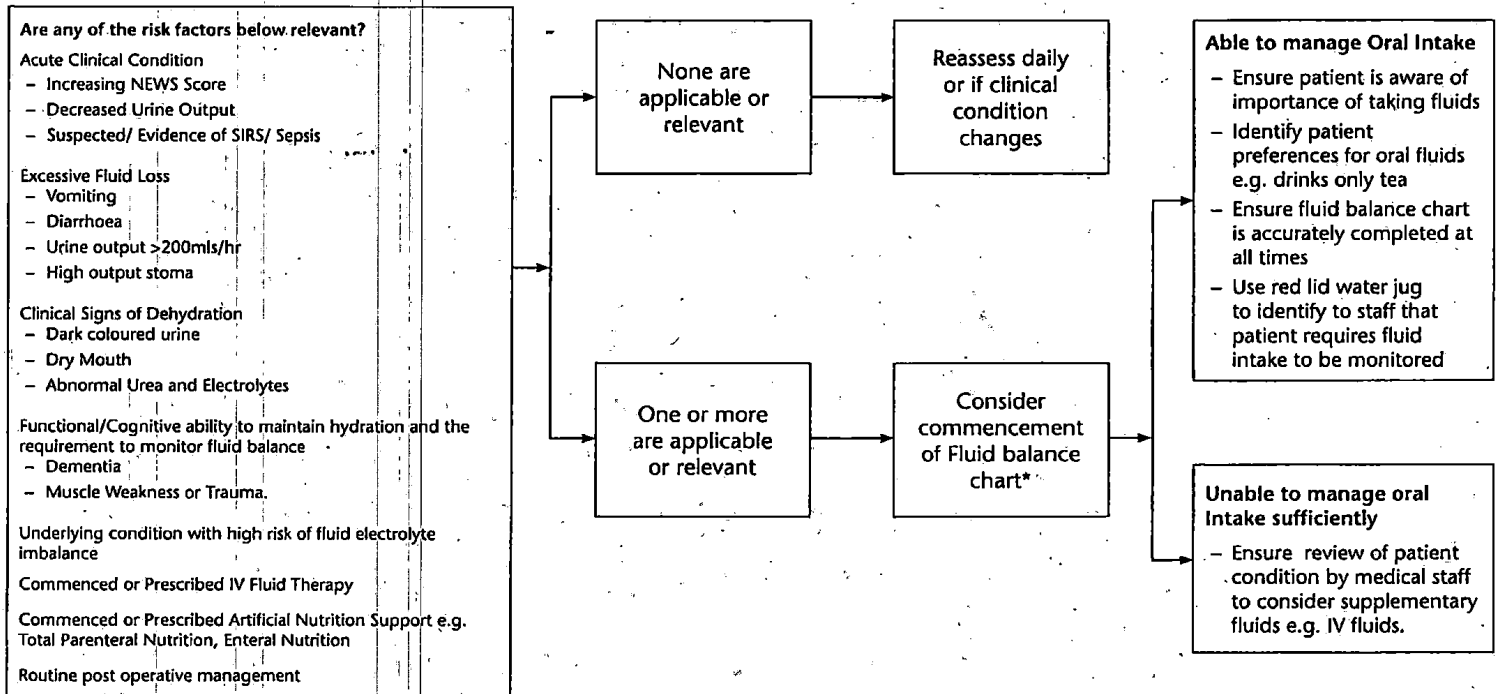
Time	Input								Output								
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff **MUST** review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

Date: 10 / 2 / 26

1. Signed EM Name EMcGiverny Designation SN
2. Signed broome Name Rebecca Broome Designation SN
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

NHS
Greater Glasgow
and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

		Times	0000	0005	0010	0015	0020	0025	0030	0035	0040	0045	0050	0055	0100	0105	0110	0115	0120	0125	0130	0135	0140	0145	0150	0155	0200	0205	0210	0215	0220	0225	0230	0235	0240	0245	0250	0255	0300	0305	0310	0315	0320	0325	0330	0335	0340	0345	0350	0355	0400	0405	0410	0415	0420	0425	0430	0435	0440	0445	0450	0455	0500	0505	0510	0515	0520	0525	0530	0535	0540	0545	0550	0555	0600	0605	0610	0615	0620	0625	0630	0635	0640	0645	0650	0655	0700	0705	0710	0715	0720	0725	0730	0735	0740	0745	0750	0755	0800	0805	0810	0815	0820	0825	0830	0835	0840	0845	0850	0855	0900	0905	0910	0915	0920	0925	0930	0935	0940	0945	0950	0955	1000	1005	1010	1015	1020	1025	1030	1035	1040	1045	1050	1055	1100	1105	1110	1115	1120	1125	1130	1135	1140	1145	1150	1155	1200	1205	1210	1215	1220	1225	1230	1235	1240	1245	1250	1255	1300	1305	1310	1315	1320	1325	1330	1335	1340	1345	1350	1355	1400	1405	1410	1415	1420	1425	1430	1435	1440	1445	1450	1455	1500	1505	1510	1515	1520	1525	1530	1535	1540	1545	1550	1555	1600	1605	1610	1615	1620	1625	1630	1635	1640	1645	1650	1655	1700	1705	1710	1715	1720	1725	1730	1735	1740	1745	1750	1755	1800	1805	1810	1815	1820	1825	1830	1835	1840	1845	1850	1855	1900	1905	1910	1915	1920	1925	1930	1935	1940	1945	1950	1955	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050	2055	2100	2105	2110	2115	2120	2125	2130	2135	2140	2145	2150	2155	2200	2205	2210	2215	2220	2225	2230	2235	2240	2245	2250	2255	2300	2305	2310	2315	2320	2325	2330	2335	2340	2345	2350	2355	2400	2405	2410	2415	2420	2425	2430	2435	2440	2445	2450	2455	2500	2505	2510	2515	2520	2525	2530	2535	2540	2545	2550	2555	2600	2605	2610	2615	2620	2625	2630	2635	2640	2645	2650	2655	2700	2705	2710	2715	2720	2725	2730	2735	2740	2745	2750	2755	2800	2805	2810	2815	2820	2825	2830	2835	2840	2845	2850	2855	2900	2905	2910	2915	2920	2925	2930	2935	2940	2945	2950	2955	3000	3005	3010	3015	3020	3025	3030	3035	3040	3045	3050	3055	3100	3105	3110	3115	3120	3125	3130	3135	3140	3145	3150	3155	3200	3205	3210	3215	3220	3225	3230	3235	3240	3245	3250	3255	3300	3305	3310	3315	3320	3325	3330	3335	3340	3345	3350																																																																																																																																																																																																																																																																																			
1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Attach Addressograph Label



Ward:.

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

[illegible]

Fluid Balance Chart

N 0712726128
D SULLIVAN 07/12/1972 F
Deborah
Flat 0-1, 8 Boyndie Street
C Easterhouse
Glasgow, Lanarkshire G34 9JE
A/R

Hospital: GRI
Ward: GS
Date: 10/12/26

Reason for Fluid Balance Chart Monitor
Is patient fluid restricted? Yes ☐ No ☒
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☒ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

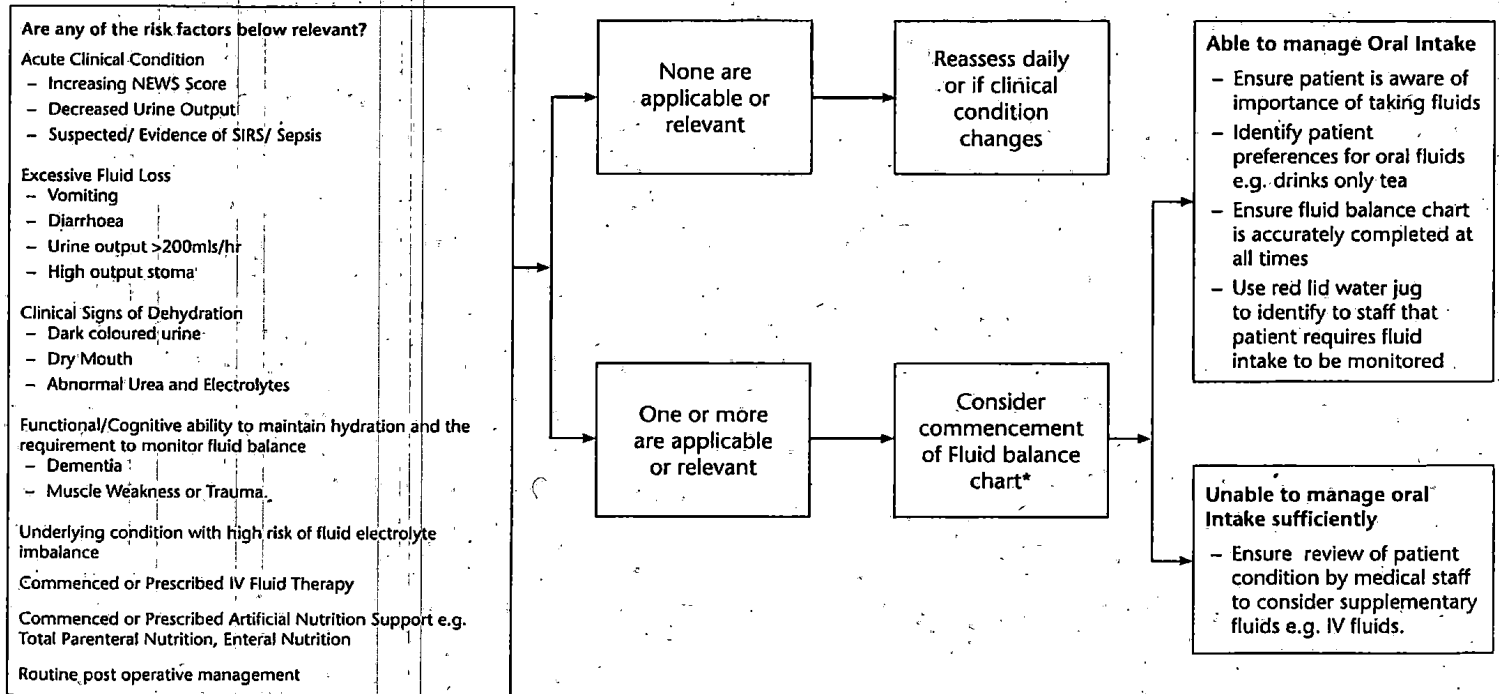
Time	Input								Running Total INPUT	Output			Type	Type	Type	Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel					
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00	TEA	200															
08:00																	
09:00	MILK	250								350							
10:00	TEA	200								500							
11:00	MILK	250															
12:00	SALAD	150															
13:00	MILK	150								200							
14:00	TEA	100															
15:00																	
16:00										250							
17:00	MILK	150															
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake									1150	*Total Output							430

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid
Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

***Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes**

Date: 09/02/26

1. Signed: Droule Name Rebecca Cande Designation SN
2. Signed EM Name B. Maguire Designation SN
3. Signed _____ Name _____ Designation _____

[illegible]

G34 9JE

NO Thank



		Times	0800	0900	1015	1200	1400	1600	1800	2000	2200	2300	2400
1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	A	N	N	N						
2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	A	N	N	N						
5	3 SKIN INSPECTION Pressure areas checked: Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		N	A	I	I	N						
K	4 KEEP MOVING Has the patient moved or walked? Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B Chair Assist to walk or stand (W/ST)		S	S	I	I	Y						
I	5 ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	S	I	I	I						
N	6 FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplement taken? Has oral hygiene been carried out as per care plan?		S	S	N	N	N						
	7 ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		S	S	Y	Y	Y						
	8 INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		S	S	N	N	N						
	9 ESCALATION Escalate any issues to the registered nurse and document overleaf.		S	S	N	N	N						
	Care provider / role		CP	CP	MS	MS	CP						

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Fluid Balance Chart

N: 0712726128 Dr SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: <u>C21</u> Ward: <u>105</u> Date: <u>09/02/26</u>	Reason for Fluid Balance Chart _____ Is patient fluid restricted? Yes ☐ No ☐ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: <u>P. Cawo</u> Designation: <u>SN</u>
---	---	---	--

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

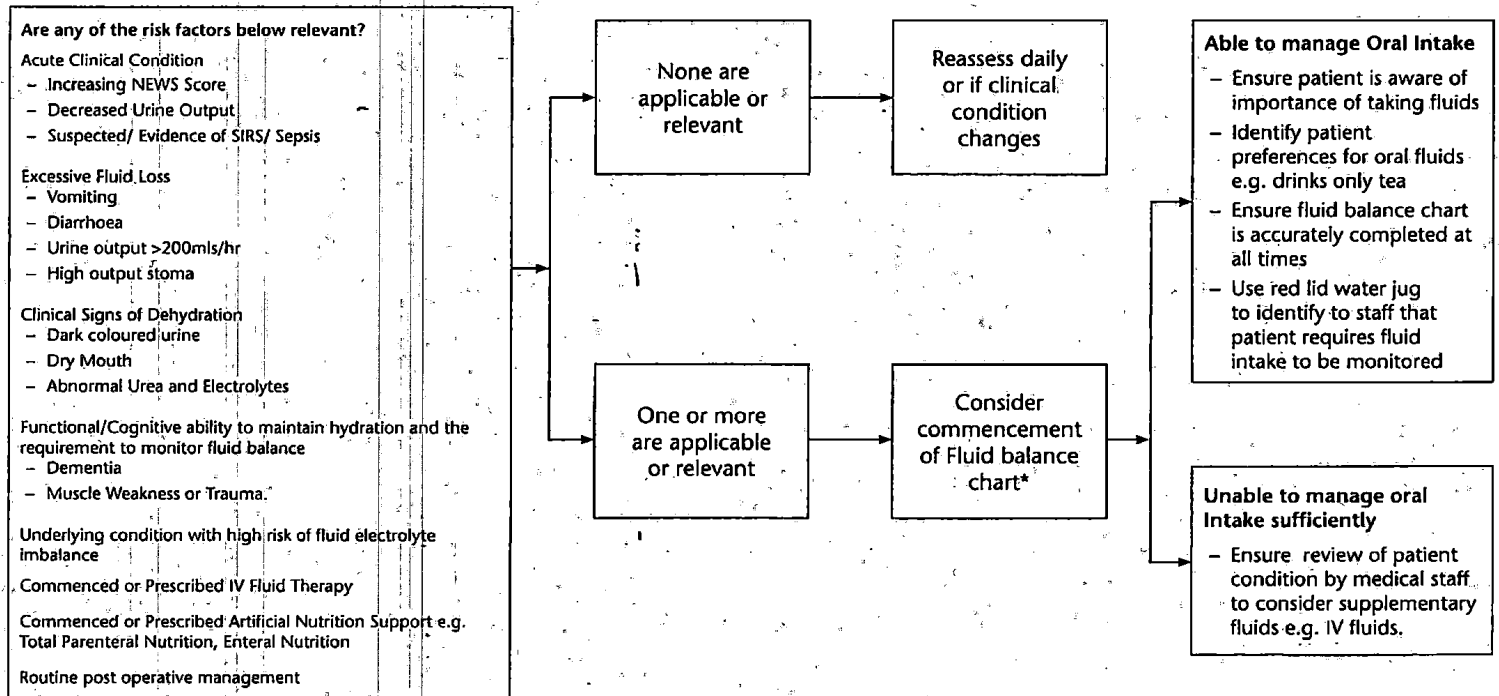
Time	Input				IV / Other				Running Total INPUT	Output			Output			Running Total OUTPUT	Initials
	Oral Fluids Type	Volume	Enteral Type	Volume	Type	Volume	Type	Volume		Urine	Gastric / Vomit	Bowel	Type	Type	Type		
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00	Tea	200															
21:00																	
22:00																	
23:00																	
*Total Intake									2750								
										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid
Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



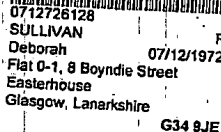
Medical staff **MUST** review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

Date: 8/2/26

1. Signed [Signature] Name Arconian Designation JN
2. Signed [Signature] Name R. Maza Designation SN
3. Signed Promo Name Rebecca Ome Designation SN

Attach Address



Ward:

Kept updated

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Ati  F
0712728128
SULLIVAN 07/12/1972
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
Wai G34 9JE



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Fluid Balance Chart

 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: <u>GL</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
	Ward: <u>63</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
	Date: <u>08/02/26</u>	If yes how many mls in 24 hours? _____	1. Type _____ circle how many daily 1 2 3
	Fluid balance from previous 24hrs +/- _____		2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____			

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

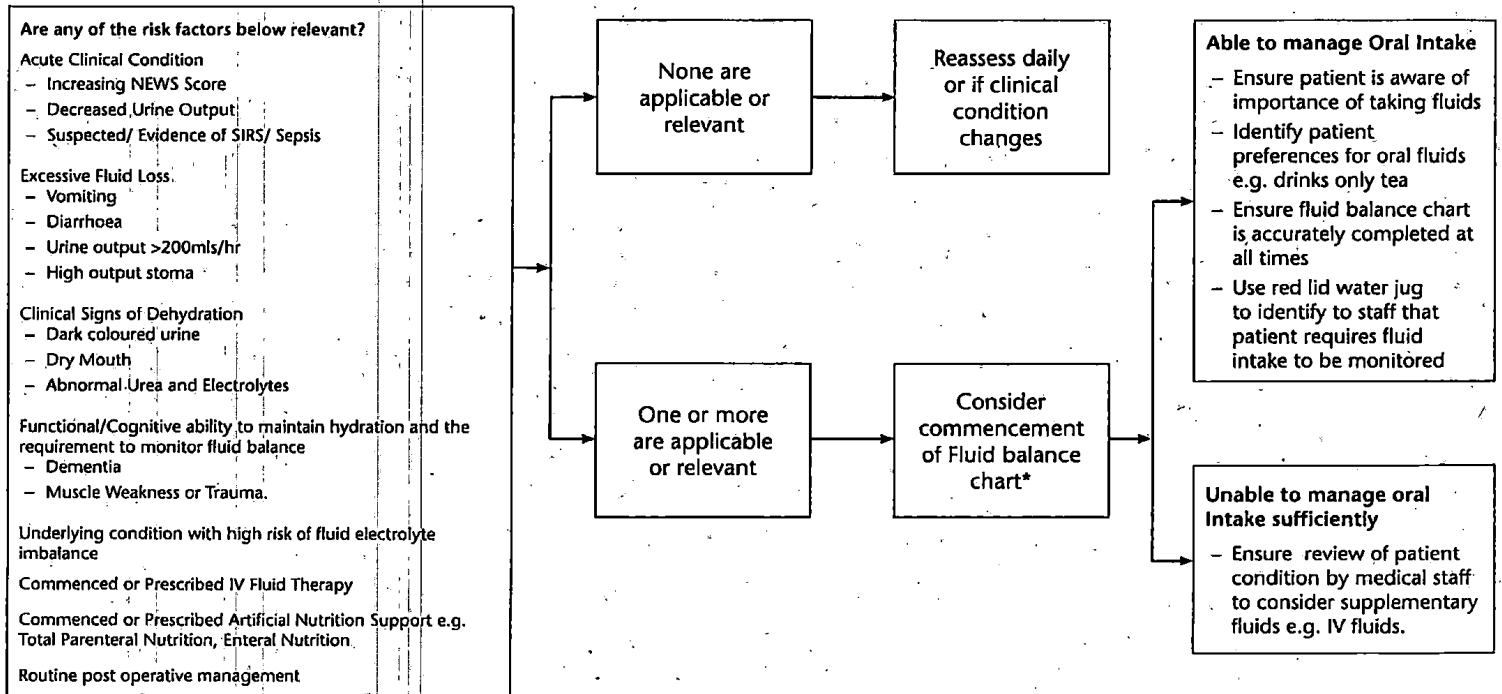
Time	Input				IV / Other				Running Total INPUT	Output			Running Total OUTPUT	Initials					
	Oral Fluids		Enteral							Urine	Gastric / Vomit	Bowel							
	Type	Volume	Type	Volume	Type	Volume	Type	Volume											
00:00																			
01:00																			
02:00																			
03:00																			
04:00																			
05:00																			
06:00	tea	250																	
07:00										100									
08:00																			
09:00	water	250			IVFS	500				200									
10:00																			
11:00																			
12:00										200									
13:00	tea	250																	
14:00																			
15:00	water	250								300									
16:00																			
17:00	tea	250								100									
18:00					IVFS	500				200									
19:00	water	250																	
20:00										300									
21:00	tea	250																	
22:00										300									
23:00																			
		1750				Y/SS													
*Total Intake									1750	*Total Output									1700

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid
Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

Date: 07/02/26

1. Signed [Signature] Name John Langman Designation SW
2. Signed _____ Name _____ Designation _____
3. Signed [Signature] Name arcovis Designation SW

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

63

No Thanks

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Fluid Balance Chart

 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: <u>GRI</u> Ward: <u>G3</u> Date: <u>07/02/26</u>	Reason for Fluid Balance Chart _____ Is patient fluid restricted? Yes ☐ No ☐ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: _____ Designation: _____
---	--	---	---

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

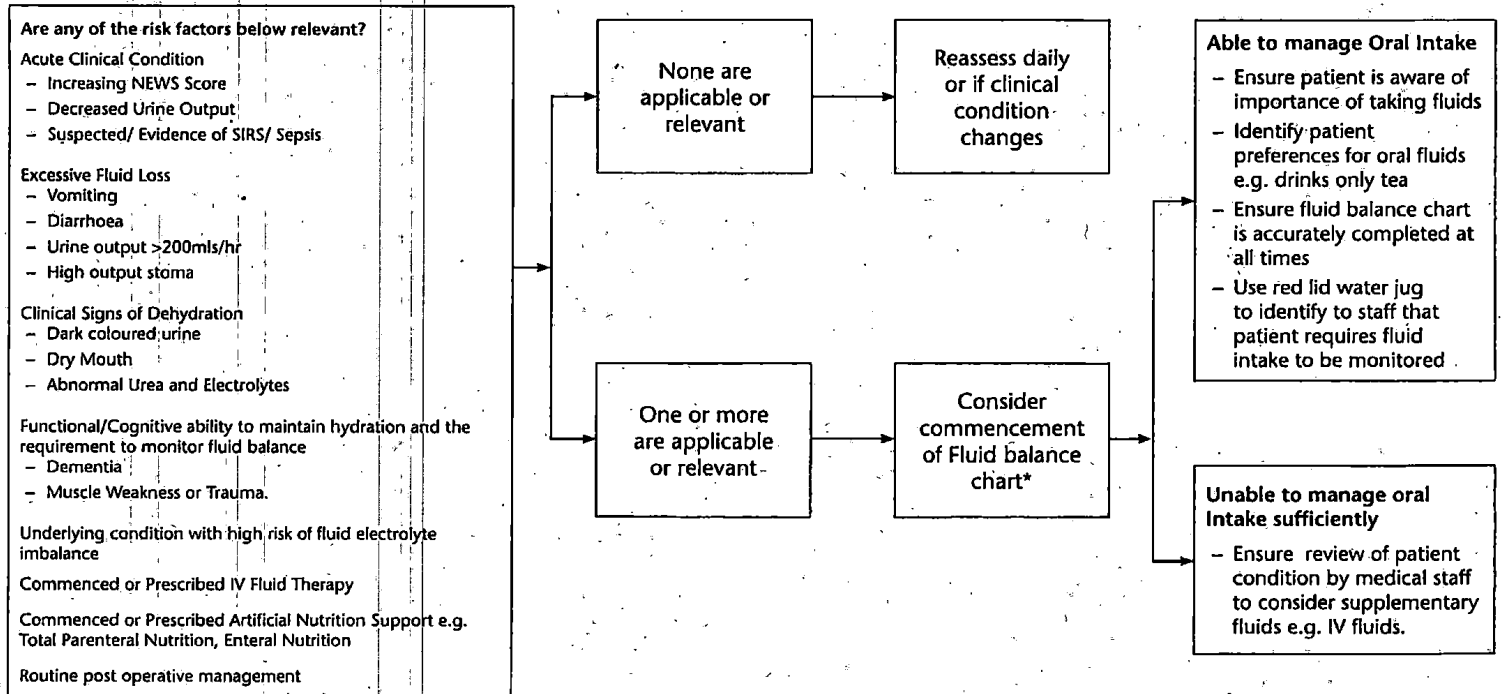
Time	Input								Output								
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid
Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff **MUST** review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

Date: 06/02/24

1. Signed Czyzowski Name H. Czyzowski Designation SW
2. Signed Flindray Name FLINDRAY Designation SW
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

07/12/1972

Ward
63

10 hauls

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

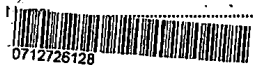
Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Fluid Balance Chart

 0712726128 SULLIVAN Deborah Flat 0-1, 8 Boydrie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: <u>GRI</u>	Reason for Fluid Balance Chart _____	Does patient require thickened fluids? Yes ☐ No ☐ Stage _____	 NHS Greater Glasgow and Clyde
	Ward: <u>63</u>	Is patient fluid restricted? Yes ☐ No ☐	Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:	
	Date: <u>6/2/28</u>	If yes how many mls in 24 hours? _____	1. Type _____ circle how many daily 1 2 3	
	Fluid balance from previous 24hrs +/- _____		2. Type _____ circle how many daily 1 2 3	
Signature: _____ Designation: _____				

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

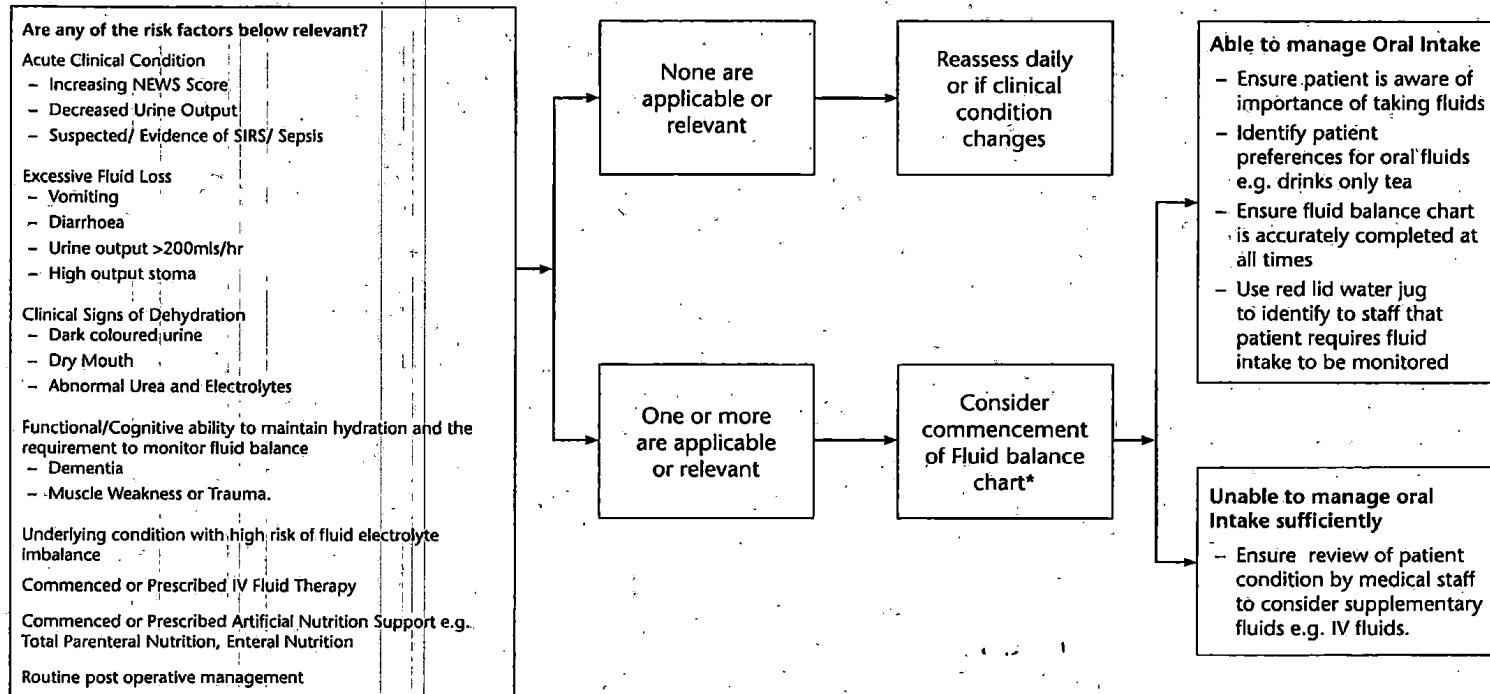
Time	Input								Running Total INPUT	Output			Type	Type	Type	Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel					
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr-Fluid
Balance +/-

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

My Admission Record



Hospital: GRC Ward: 64
 Date of Admission: 19/3/25 Time: 22.00
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐
Preferred Name: _____
 Age: 52 Telephone Number: _____
 Consultant: Duxbury

Nat 0712725128
 Ad F SULLIVAN
2 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 Do _____
 CHE _____ G34 9J
 Affl. _____

Communication

What is your first language? English
 Do you require an interpreter? Yes ☐ No ☒
 If yes, provide details of arrangements made _____
 Do you use British Sign Language (BSL)? Yes ☐ No ☒
 Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact

Name: Robert Glass
 Relationship: partner
 Address: _____
 Telephone: 07597389233
 Is this person aware of your admission?
 Yes ☒ No ☐
 Can we share information with this person?
 Yes ☒ No ☐

Preferred second contact

Name: _____
 Relationship: _____
 Address: _____
 Telephone: _____
 Is this person aware of your admission?
 Yes ☐ No ☐
 Can we share information with this person?
 Yes ☐ No ☐

Presenting Complaint / Diagnosis

abdo pain + vomiting
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ pen

Relevant past medical history

HTN T chol cholecystectomy
Type 2 DM - on insulin appendectomy
Fibromyalgia

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
 Yes ☐ No ☒ If yes, Who asked for a copy? _____
 Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity		Name Addr 0712728128 SULLIVAN Deborah 07/12/1972 DoB _____ CHI: _____ Affix patient ID label _____
Does someone have Power of Attorney (POA) for you? Yes ☐ No ☒		
OR Does someone have Guardianship? Yes ☐ No ☒		
If yes, is this for:- Finance ☐ Welfare ☐ Both ☐		
Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐		
Please obtain a copy and place in the patient's notes.		
Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____		
POA/ Guardian Name: _____ Relationship: _____ Contact Tel Number _____ Name: _____ Relationship: _____ Contact Tel Number _____		
N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47		

Carbapenemase-producing enterobacteriaceae (CPE)			
Have you ever:			
1. Been an inpatient in a hospital outside Scotland?	Yes ☐	No ☒	
2. Received holiday dialysis outside Scotland?	☐	☒	
3. Been told that you have CPE?	☐	☒	
4. Been in close contact with a person with CPE?	☐	☒	
If the answer is yes to ANY of the questions in this section, you must			
Isolate the patient in a side room	☐		
Obtain Rectal swab marked 'for CPE'	☐		
If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'	☐		
and inform the IPCT	☐		
MRSA Screening			
Will the patient be an inpatient for more than 23 hours	Yes ☒	No ☐	Unsure ☐
If YES complete the following section			
1. Have you ever been told that you have MRSA?	☐	☒	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☒	☐
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☒
If YES to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs			
Nasal ☐ Perineum ☐ Other ☐ Specify _____	Patient refused ☐		
Creutzfeldt-Jakob Disease (CJD)			
Have you ever been informed that you are at increased risk of CJD or vCJD?	Yes ☐	No ☒	Unsure ☐
If YES inform the IPCT ☐			

Name		
Address	0742726128	
	SULLIVAN	F
	Deborah	07/12/1972
	Flat 0-1, 8 Boydrie Street	
DoB:	Easterhouse	
CHI:	Glasgow, Lanarkshire	
Affix patient ID label	G34 9JE	

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☒ when did you stop? _____

Never smoked ☐

Do you use eCigarettes? Yes ☒ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): *Lynne Gilman*

Signature: *[Signature]*

Designation: *rgn*

Date: *18/3/25*

My Assessment Record

Name	
Address	0712726128 SULLIVAN Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire
DoB:	
CHI:	G34 9JE
Affix patient ID label	

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓		new O2 requirement
Breathless at rest		✓	
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team?			
Contact details:			

Na _____
 Ad _____
 0712726128
 SULLIVAN
 Deborah
 D _____
 C _____
 A _____
 07/12/1972

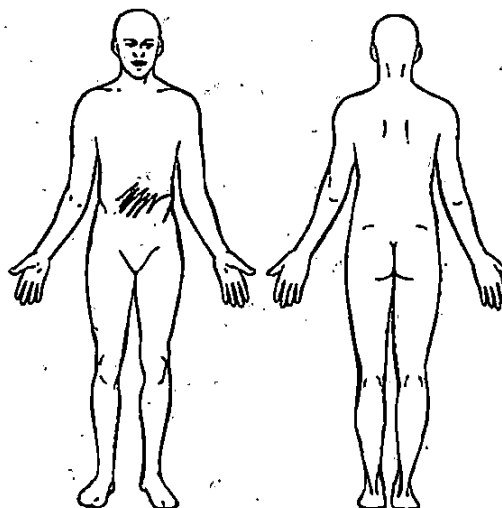
B. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Name _____
 Addre _____
 0712726128
 SULLIVAN
 Deborah F
 Flat 0-1, 8 Boyndie Street 07/12/1972
 Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix patient ID label G34 9JE

4. Cognitive Status **THINK DELIRIUM**

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

nil known

What do you like to eat and drink?

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Name: A:  0712726128 SULLIVAN Deborah Flat 0-1, 8, Boyndie Street CHI: Easterhouse Glasgow, Lanarkshire Affix: G34 9JE
Normal diet and fluids	✓	✓	Assessment of the patient's hydration and nutrition needs
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour: _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: _____ DoB: _____ CHI: _____ Affix patient ID label
Haematuria			 0712726128 SULLIVAN Deborah : Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire 07/12/1972 G34 9JE
Incontinent			

N.B. If new Incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) In situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? *Today 18/3/25*

How often in a day/week do you have a bowel movement? Per day Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☒ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	<i>lactulose at times</i>
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

Name: _____
 Address: 0712726128
 SULLIVAN
 Deborah 07/12/1972
 Flat 0-1, 8, Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 Affix patient ID: 634 9JE

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation	Normal for the patient	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation	Normal for the patient	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes	No	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation	Normal for the patient	Assessment of the patient's skin care needs
No problems		✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name:  Address: 0712726128 SULLIVAN Deborah 07/12/1972 F Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire DoB: _____ CHI: _____ G34 9J Affix patient ID label
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	
8. Mobility			
Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent			could not a crutch when fibro plays up
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	
N.B. If not fully mobile and Independent on admission complete moving and handling assessment within 24 hours of admission			
9. Maintaining a Safe Environment			
N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.			
Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	
N.B. If yes, to either of the two questions above complete a bedrail risk assessment			
10. Sleep and Rest			
Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

Name:		
Add:	0712726128	
	SULLIVAN	F
	Deborah	07/12/1972
DoB:	Flat 0-1, 8 Boyndie Street	
CHI:	Easterhouse	
	Glasgow, Lanarkshire	G34 9J
Affix:		

11. Social Circumstances

Do you:

Live alone

☒

Live with family/ friend/ other

☐

Live in a nursing home

☐

Live in a care home

☐

Live in residential supported care

☐

Live in student accommodation

☐

Live in 'homeless' accommodation

☐

Have no fixed abode

☐

Other please specify

☐

Dependants

Yes

No

Do you have any dependants?

☒
☐

Do you support anyone (e.g. partner, children, relatives, animals)?

☐
☒

Do they need support from someone else whilst you are in hospital?

☐
☐

Would someone else be able to provide this support when you are in hospital?

If yes, who?

☐
☐

If no support available contact Duty Social Worker

Duty Social Worker Required

☐

Not required

☐

Referred

☐

Services

Yes

No

Do you have support from social work, social services or a care package?

☒
☐

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?

☐
☐

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Catholic

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed

Yes ☐

N/A ☒

Name:		—
	0712726128	—
Address:	SULLIVAN	—
	Deborah	F —
	07/12/1972	—
	Flat 0-1, 8 Boyndie Street	—
	Easterhouse	—
	Glasgow, Lanarkshire	—
DoB:		—
CHI:		G34 9J —
Affix patient ID label		

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
 This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?
 Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
 (please tick) Yes ☐ No ☐

Name: 
 Address: 0712726128
 SULLIVAN
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 CHI: G34 9JF
 Affix

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☒ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☒

Are you:

Employed ☐

Self-employed ☐

Full time education ☐

Unemployed ☒

Retired ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ____/____/____

Risk Assessments/Other Documentation

Name 
 Address 0712726128
 F SULLIVAN
 2 Deborah 07/12/197
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 DoB: G34 9J
 CHI: E
 Affix patient ID label

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓			
Generic Pain Scale Assessment Chart		✓			
Abbey Pain Scale (if unable to self report pain)		✓			
4AT and TIME for Detection, Management and Prevention of Delirium		✓			
Getting to Know Me - Relatives to complete		✓			
What Matters to Me		✓			
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓			
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart		✓			
Moving and Handling Assessment	✓				
Falls Risk Assessment	✓				
Bedrail Risk Assessment		✓			

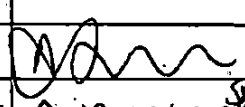
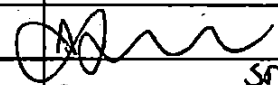
Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
18/3/25	Admitted with ddxo pain & vomiting	
2200pm	For Cxer on ward 11	
	of Sats ↓ in A+E connected	
	on 2L of via n/c	
	98% on 2L reduced to	
	1Litre.	

Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
00.00	A- NEWS as charted.	
19/3/25	B- Risk assessment completed.	
	C- Awaiting urine sample	
	Mobilising independently.	
	Tolerating sips of CF.	
	Awaits surgical review.	
	D- No new concerns at present	A-DUNCAN ^{SW}
08.05	Reviewed on ward.	
	? Gastroparesis ? Gastritis	
	? pancreatitis. Plan:	
	- IV fluids.	
	- Analgesia.	
	- omeprazole 40mg BD.	
	- Antiemetics	
	- Urine amylase.	
	- CXR.	A-DUNCAN ^{SW}
0945	WR AM: • CTAP	Nmaguire ^{SW}
14:00	All charts r/v & updated	
	Tolerating DIF	
	News of (4) LL ^{OL} , dbp 110	
	Medication given as per hepma.	
	Ind 1 self caring.	
	Await GST report.	Nmaguire ^{SW}
15 ⁰⁰	Pt hypo as CT due to long wait	
	and having all morning.	
	Glucose juice given & BM 6.3	Nmaguire ^{SW}

5th 9
9370

Name: _____
Address: _____

DoB: _____
CHI: _____
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
00.00	A-Obs as charted NEWS stable	
20/3/25	B-Checked & up to date.	
	C-Meds as per Hepma	
	Passing urine freely	
	Mobilising independently	
	Tolerating Diet & fluids	
	For transfer to ward 49.	
	D-NO new concerns at present	A. DUNCAN SR
20/3/25	A-news 0	
00.30	B-checked & up to date.	
	C-analgesia given as patient request	
	D-nil	ERIDIE SR
20/3/25	A- NEWS score (1) due to	
15.20	pulse: 101.	
	B- Charts up to date	
	C- Patient awaits ward	
	round. Patient administered	L MacLeod
	medications from dosette box.	L MALLON
	D- Nil	STAFF NURSE
21/03/25	A-news stable	
22.00	- ENO since then - lactulose given	
	B-checked & up to date.	
	C- Took metformin at 1700	
	instead of 2200 patient reports	
	D-nil	ERIDIE SR

CLINICAL NOTES - MEDICAL NURSING

074938

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

G34 9JE

1. **UNIVERSITY OF CALIFORNIA, BERKELEY**

[illegible]

Insulin Prescription and Administration Form



Name: 

Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire G34 9JE

Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☒

Self administering insulin: Yes ☒ No ☐

Usual diabetes medication and device:
20 Units HUMULIN I.

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and administration times are also prescribed on the Kardex.
Administration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: 4 /day.

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
20/03						units					Y / N
						units					Y / N
	Before Breakfast	9.2			HUMULIN I	20	Nicola White MSc	ER	GW	0650	Y / N
						units					Y / N
	Before Lunch	9.2				units					Y / N
	12:15pm					units					Y / N
	Before Dinner	13.2				units					Y / N
	19:50	14.9				units					Y / N
21/03/20	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast	10.2			HUMULIN I	22	F. McNair	ER	GW	0650	Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
	Before Bed					units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
						units					Y / N
	Before Bed					units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/L
Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet Urgent medical review if unwell/deteriorating at any stage. Mild and able to swallow: 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice Severe: 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic) Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but do not omit insulin in type 1 diabetes.	Check urine or blood for ketones – need urgent medical review if ketones present or if unwell. Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion. Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes. If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check Injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name:

Address:

DoB:

Chi number:

Affix patient data label

Write on this label N A 0712726128 C SULLIVAN 07/12/197 D Deborah H Flat 0-1, 8 Boydrie Street Easterhouse Glasgow, Lanarkshire G34 9J	Peripheral Venous Cannula (PVC) Insertion & maintenance Please complete insertion details for each PVC inserted Care & maintenance to be undertaken & documentation completed twice each day.	Modified Visual Infusion Phlebitis (VIP) Score	
		PVC site appears healthy	0 No phlebitis: Continue care and maintenance
		Either slight pain or redness near site	1 Possible first signs: Observe PVC site
		Two or more: pain / redness / swelling	2 Early stage of phlebitis: Remove and resite PVC
		All: pain / redness / hardening of surrounding area	3 Phlebitis/thrombophlebitis: Remove and resite PVC
As above and including: palpable venous cord	4 Seek further advice		
As above and including: pyrexia	5		

Insertion details: Date: 18/3/25 (Day 1) Time: 02:00	Where inserted: ☒ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown	Insertion site: ☐ Hand ☒ Arm Other:	Side: ☐ Left ☐ Right	Size of cannula: ☐ 26G Purple ☒ 24G Yellow ☐ 23G Blue ☐ 20G Pink ☐ 18G Green ☐ 16G Grey ☐ 14G Orange	Inserted by: Print: A E Steff Signature: _____ Designation: _____
Clinical Indication: ☐ Diagnostics ☐ Resuscitation ☐ IV medications ☐ Fluids ☐ Transfusion					
Insertion criteria: Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No		

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.		Signs of local or systemic infection	
Justify the need for your patient to have a PVC using the DRIFT mnemonic. ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest? ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route? ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?		Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness Systemic Infection • Hypotension • Tachycardia • Pyrexia	

Adult IVOST Guideline: 	Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines IV → Oral Antibiotic Switch Therapy (IVOST) Guideline		Paediatric IVOST Guideline: 
	Review need for IV antibiotics daily Can antibiotic therapy be stopped? (eg: alternative diagnosis?) If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours		
	Switch to oral when: a CLINICAL IMPROVEMENT in signs of infection eg: temperature $\leq 37.9^{\circ}\text{C}$; reduction in the NEWS score, improving SEPSIS a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption) a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureus bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess. DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness Record the stop date on HEPMA		
	If IVOST criteria met → Switch to oral Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures IF not responsive MICROBIOLOGY switch to oral as outlined below		

PVCs should be removed as soon as no longer clinically indicated.

Write or affix label

Name:
Address:
CHI:
DOB:
Hospital & Ward:

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 19/3/25	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 2 19/3/25	☒ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP _____	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <i>Nm</i> Night
Day 3 20/3/25	☒ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP _____	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <i>K. Parleed</i> Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed 20/9/25

Reason for removal	☐ Site infection	☐ Infiltration	☒ Extravasation	☐ End of treatment	Other:
--------------------	---	---------------------------------------	---	---	--------

Atta: 0712726128
SULLIVAN
Deborah
F
07/12/1972
Wa



1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

[illegible]

Date: 20/3/25

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) - 1hr 2hr 3hr 4hr

1. Signed [Signature] Name FRIDDLE Designation SN
2. Signed L. MURKIN Name L. MALLKOD Designation S/W
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach A

0712726128

SULLIVAN

Deborah

Flat Q-1, 8 B.

Easterhouse
Glasgow, Lanarkshire

Ward:

49

G34 9.1F

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium...	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 0712726128 SULLIVAN Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: Gri Ward: 64	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	---------------------------------	--

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily. - /

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
16/3/25	00:00	N	N	N	N	N	N	4 hrly	LL
19/3/25	00:00	N	N	N	N	N	N	4 hrly	AD
20/3/25	00:30	N	N	N	N	N	N	4 hrly	EX
21/3/25	00:00	N	N	N	N	N	N	4 hrly	EL
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.



Attach Addressograph

Outcome: To prevent pressure ulcer development through establishment of effective work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 64 Date: 15/3/25 Time: 22:00	Ward: 44 Date: 20/3/25 Time: 00:45	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	✓			
2. Check walking aid (if required) is in reach and in use.	no aid	no			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	SAFE	✓			
5. If glasses are worn, check they are available and in use.	✓	✓			
6. If hearing aid/s are worn, check they are working and in use.	no aid	no			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			✓		✓						
2. Does the patient have cognitive impairment or a possible delirium?			✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓		✓						
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓		✓						
5. Based on your clinical judgement, is this patient at high risk of falling?			✓		✓						
Signature of nurse completing assessment / update		SLU	ER								

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time: -----	Time: -----	Time: -----	Time: -----	Time: -----

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.

(Patient care plan 8)

Assess if a low bed is required

(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.

(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.

(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT

– follow THINK DELIRIUM guidelines.

(Patient care plan 4)

Document continence problems and link to care rounding

(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.

(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.

(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.

(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.

(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.

(If appropriate)

Signature of nurse completing Interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Feb 17

MI • 294647c

Version 1_0 • GGC0233

Person Specific



0712726128

F SULLIVAN

2 Deborah

07/12/197

Fiat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

G34 9J

d Handling Assessment Form

Person's Name:	Person is totally independent (tick here and go to date box)
----------------	---

1. General Information

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
93.7 kg	175 cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI 30.7		
Risk of Falls:	Yes	No

2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)

Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 2 >3	Additional Information:		

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alenti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	
	At times			

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	18/3/25	20/3/25	
Assessor's signature:	<i>[Signature]</i>	ERIDING	
Proposed Review date:		27/3/25	

Continuation Sheet

[illegible]



0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JL

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date _____ Time _____	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
of initial height and weight on admission to hospital			
Admission Height 175 cm	☐	☒	
Admission Weight 93.7 kg	☒	☐	

* Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	15/3/25						
Time	22.00						
Ward	64						
Oedema/ Ascities present Y/N	N						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	ch						
Weight (kgs)	93.7						
BMI	30.7						

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0						
Step 4 Overall Risk of Malnutrition TOTAL	0						
Rescreen on							
Signature	DM						

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ⓪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Complete the above steps

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

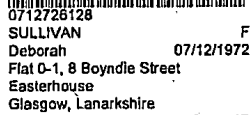
- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietitians via Trakcare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

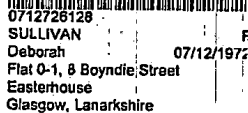




G34 9JE

NHS
Greater Glasgow
and Clyde

[illegible]



NHS
Greater Glasgow
and Clyde

Care discussed with patient Unable	☐ Yes	☒ No	☐	If unable, give reason:	
Care discussed with family Unable	☐ Yes	☒ No	☐	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
18/3/25	O ₂ L in A+E. ex-smoker now vapes new O ₂ reg'n A+E on 2L O ₂ reduced to 1L in wd b4			/	
				5. Hydration and Nutrition	
18/3/25	no issues		18/3/25	Fasting till rel	
				6. Elimination	
18/3/25	A+E		18/3/25	Reports no issues	

Date: 18/3/25

1. Signed [Signature] Name Lynne Cole Designation ggn
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach A



NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Date: 19/3/25

1. Signed [Signature] Name A. DUNCAN Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach A

07/12/2012
SULLIVAN

SULLIVAN
Robert

Deboran U
#1-2-4-A Broadway Street

Flat 0-1, 8 Bo

Glasgow, Lanarkshire

G34 9JE

Ward:

64

'Must do's' for me. Ask the patient if there is anything they want specifically done today:

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

3/

Patient name

Patient CH



0712726128

SULLIVAN

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

C6



Emergency Care Nursing Documentation

Initial Investigations

Patient prepared for exam - clothing bagged				Y	N
NEWS Chart	Y	N	X-rays	Y	N
ID band	Y	N	Pain Score	Y	N
Peak Flow	Y	N	Please specify		
12-lead ECG	Y	N	Urinalysis	Y	N
IV access	Y	N	Positive findings		
Blood samples	Y	N			
Blood Gas	Y	N	B-HCG	Y	N

Signature:

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
name, relationship, location, particular concerns		

Signature:

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Time: Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
4AT Assessment	Y	N	Frailty Assessment	Y	N
			Public Protection (NOC)	Y	N

Signature:

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Risk Assessment/Screening Tools	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

Signature:

Patient name



0712726128

SULLIVAN

F

Patient CH

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9J

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr **4hr**

Signed

Name

Designation

Signed

Name

Designation

Signed

Name

Designation

Use the following Codes:

Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times																	
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.	2																
	2	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If yes inform registered nurse.	4																
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU = Pressure Ulcer INT = Intact M = Moisture	2																
			1																
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand	4																
			B																
		ELIMINATION Does the patient need the toilet?	2																
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)	1																
		FOOD FLUIDS AND NUTRITION Is the patient nil by mouth?	2																
N	6	Drink taken?	2																
		Food, snack, or supplements taken?	2																
		Has oral hygiene been carried out as per care plan?	2																
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?	5																
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return	4																
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return	4																
		Care provider	RR																
		Role	BN																

Ask the patient if there is anything they specifically want done today:

Patient r



0712726128

Patient (

SULLIVAN

Deborah

07/12/1972



Nursing notes cont.

Date and Time

Name/Signature

Patient name

Patient CH:

0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital:

Ward:

Points to consider:

- Use within 8 hrs of admission to care area
- Re-assess daily and more frequently if a person's condition changes

NHS
Greater Glasgow
and Clyde

PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.
Date	Location of redness / ulcers	Grade of ulcer
/ /		
/ /		
/ /		
2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score > 2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____ hrly	
/ /	:							____ hrly	
/ /	:							____ hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name

Patient CHI



0712726128

SULLIVAN

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE



Greater Glasgow
and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS, PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient name



0712726128

SULLIVAN

Patient CH

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE



Greater Glasgow
and Clyde

Nursing notes

Date and Time

Name/Signature

18/03/25 Brought to bay 3 from
1813 corridor space C10

Ongoing abdominal pain

Given IV morphine

after IV access gained

Pt developed new or
requirement, analgesia
has helped pain

RRoom SW

18/3/25 2014 Care taken over by myself on night shift
duty. 4mg IV oramorph given for pain.

Observations repeated. New (2) - Kheer@

2019. Oramorph given as per Kardex - Kheer@

0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 9J

	Date	Ward	Time
Admitted			
Transferred	20/05/13	419	00:30
Transferred			
Transferred			
Transferred			

SpO2 Scale 1
Target >96%

Signature: _____
Print Name: _____
Dr/ANP initials ONLY: _____
Date: _____

SpO2 Scale 2
Target 88-92%

Signature: _____
Print Name: _____
Dr/ANP initials ONLY: _____
Date: _____

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response In Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response In Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed: _____

Medical: _____

Date: _____

Glasgow Coma Scale

Pupil Reaction and Size		Pupil Size (mm)	
1 = sluggish	2 = no reaction	3 = 1	4 = 2
5 = brisk	6 = eye closed	5 = 3	6 = 4
		7 = 5	8 = 6
Date:	19/05/13	Time:	12:00
Right eye:	4	Left eye:	4
Right arm:	4	Left arm:	4
Right leg:	4	Left leg:	4
Verbal:	5	Score:	15
Always record the best response Record right (R) and left (L) responses if there is a difference between the two sides Record right (R) and left (L) responses if there is a difference between the two sides			

0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 9J

Pain Function Score

A No limitations, activity unrestricted by pain or settles quickly

B Mild limitations, mild activity restrictions

C Moderate limitations, attempted but reluctant to continue because of pain. Seek Advice

D Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Add the patient to rate higher pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain	Moderate Pain	Severe Pain
0	1	2	3
	4	5	6
	7	8	9
	10		

NI - 316654 v5.1 - CC0264

McGavin
Ballieton Health
20 Mairies Road
Glasgow
G3 7AD

3 • Deborah Su

NEWS 2 Key 1 2 3

Date	1/11	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12	1/1	2/1	3/1	4/1	5/1	6/1	7/1	8/1	9/1	10/1	11/1	12/1	13/1	14/1	15/1	16/1	17/1	18/1	19/1	20/1	21/1	22/1	23/1	24/1	25/1	26/1	27/1	28/1	29/1	30/1	31/1	1/2	2/2	3/2	4/2	5/2	6/2	7/2	8/2	9/2	10/2	11/2	12/2	13/2	14/2	15/2	16/2	17/2	18/2	19/2	20/2	21/2	22/2	23/2	24/2	25/2	26/2	27/2	28/2	29/2	30/2	31/2	1/3	2/3	3/3	4/3	5/3	6/3	7/3	8/3	9/3	10/3	11/3	12/3	13/3	14/3	15/3	16/3	17/3	18/3	19/3	20/3	21/3	22/3	23/3	24/3	25/3	26/3	27/3	28/3	29/3	30/3	31/3	1/4	2/4	3/4	4/4	5/4	6/4	7/4	8/4	9/4	10/4	11/4	12/4	13/4	14/4	15/4	16/4	17/4	18/4	19/4	20/4	21/4	22/4	23/4	24/4	25/4	26/4	27/4	28/4	29/4	30/4	31/4	1/5	2/5	3/5	4/5	5/5	6/5	7/5	8/5	9/5	10/5	11/5	12/5	13/5	14/5	15/5	16/5	17/5	18/5	19/5	20/5	21/5	22/5	23/5	24/5	25/5	26/5	27/5	28/5	29/5	30/5	31/5	1/6	2/6	3/6	4/6	5/6	6/6	7/6	8/6	9/6	10/6	11/6	12/6	13/6	14/6	15/6	16/6	17/6	18/6	19/6	20/6	21/6	22/6	23/6	24/6	25/6	26/6	27/6	28/6	29/6	30/6	31/6	1/7	2/7	3/7	4/7	5/7	6/7	7/7	8/7	9/7	10/7	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7	31/7	1/8	2/8	3/8	4/8	5/8	6/8	7/8	8/8	9/8	10/8	11/8	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8	22/8	23/8	24/8	25/8	26/8	27/8	28/8	29/8	30/8	31/8	1/9	2/9	3/9	4/9	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	13/9	14/9	15/9	16/9	17/9	18/9	19/9	20/9	21/9	22/9	23/9	24/9	25/9	26/9	27/9	28/9	29/9	30/9	31/9	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	13/10	14/10	15/10	16/10	17/10	18/10	19/10	20/10	21/10	22/10	23/10	24/10	25/10	26/10	27/10	28/10	29/10	30/10	31/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11	8/11	9/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	31/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12	1/13	2/13	3/13	4/13	5/13	6/13	7/13	8/13	9/13	10/13	11/13	12/13	13/13	14/13	15/13	16/13	17/13	18/13	19/13	20/13	21/13	22/13	23/13	24/13	25/13	26/13	27/13	28/13	29/13	30/13	31/13	1/14	2/14	3/14	4/14	5/14	6/14	7/14	8/14	9/14	10/14	11/14	12/14	13/14	14/14	15/14	16/14	17/14	18/14	19/14	20/14	21/14	22/14	23/14	24/14	25/14	26/14	27/14	28/14	29/14	30/14	31/14	1/15	2/15	3/15	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	13/15	14/15	15/15	16/15	17/15	18/15	19/15	20/15	21/15	22/15	23/15	24/15	25/15	26/15	27/15	28/15	29/15	30/15	31/15	1/16	2/16	3/16	4/16	5/16	6/16	7/16	8/16	9/16	10/16	11/16	12/16	13/16	14/16	15/16	16/16	17/16	18/16	19/16	20/16	21/16	22/16	23/16	24/16	25/16	26/16	27/16	28/16	29/16	30/16	31/16	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	13/17	14/17	15/17	16/17	17/17	18/17	19/17	20/17	21/17	22/17	23/17	24/17	25/17	26/17	27/17	28/17	29/17	30/17	31/17	1/18	2/18	3/18	4/18	5/18	6/18	7/18	8/18	9/18	10/18	11/18	12/18	13/18	14/18	15/18	16/18	17/18	18/18	19/18	20/18	21/18	22/18	23/18	24/18	25/18	26/18	27/18	28/18	29/18	30/18	31/18	1/19	2/19	3/19	4/19	5/19	6/19	7/19	8/19	9/19	10/19	11/19	12/19	13/19	14/19	15/19	16/19	17/19	18/19	19/19	20/19	21/19	22/19	23/19	24/19	25/19	26/19	27/19	28/19	29/19	30/19	31/19	1/20	2/20	3/20	4/20	5/20	6/20	7/20	8/20	9/20	10/20	11/20	12/20	13/20	14/20	15/20	16/20	17/20	18/20	19/20	20/20	21/20	22/20	23/20	24/20	25/20	26/20	27/20	28/20	29/20	30/20	31/20	1/21	2/21	3/21	4/21	5/21	6/21	7/21	8/21	9/21	10/21	11/21	12/21	13/21	14/21	15/21	16/21	17/21	18/21	19/21	20/21	21/21	22/21	23/21	24/21	25/21	26/21	27/21	28/21	29/21	30/21	31/21	1/22	2/22	3/22	4/22	5/22	6/22	7/22	8/22	9/22	10/22	11/22	12/22	13/22	14/22	15/22	16/22	17/22	18/22	19/22	20/22	21/22	22/22	23/22	24/22	25/22	26/22	27/22	28/22	29/22	30/22	31/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23	10/23	11/23	12/23	13/23	14/23	15/23	16/23	17/23	18/23	19/23	20/23	21/23	22/23	23/23	24/23	25/23	26/23	27/23	28/23	29/23	30/23	31/23	1/24	2/24	3/24	4/24	5/24	6/24	7/24	8/24	9/24	10/24	11/24	12/24	13/24	14/24	15/24	16/24	17/24	18/24	19/24	20/24	21/24	22/24	23/24	24/24	25/24	26/24	27/24	28/24	29/24	30/24	31/24	1/25	2/25	3/25	4/25	5/25	6/25	7/25	8/25	9/25	10/25	11/25	12/25	13/25	14/25	15/25	16/25	17/25	18/25	19/25	20/25	21/25	22/25	23/25	24/25	25/25	26/25	27/25	28/25	29/25	30/25	31/25	1/26	2/26	3/26	4/26	5/26	6/26	7/26	8/26	9/26	10/26	11/26	12/26	13/26	14/26	15/26	16/26	17/26	18/26	19/26	20/26	21/26	22/26	23/26	24/26	25/26	26/26	27/26	28/26	29/26	30/26	31/26	1/27	2/27	3/27	4/27	5/27	6/27	7/27	8/27	9/27	10/27	11/27	12/27	13/27	14/27	15/27	16/27	17/27	18/27	19/27	20/27	21/27	22/27	23/27	24/27	25/27	26/27	27/27	28/27	29/27	30/27	31/27	1/28	2/28	3/28	4/28	5/28	6/28	7/28	8/28	9/28	10/28	11/28	12/28	13/28	14/28	15/28	16/28	17/28	18/28	19/28	20/28	21/28	22/28	23/28	24/28	25/28	26/28	27/28	28/28	29/28	30/28	31/28	1/29	2/29	3/29	4/29	5/29	6/29	7/29	8/29	9/29	10/29	11/29	12/29	13/29	14/29	15/29	16/29	17/29	18/29	19/29	20/29	21/29	22/29	23/29	24/29	25/29	26/29	27/29	28/29	29/29	30/29	31/29	1/30	2/30	3/30	4/30	5/30	6/30	7/30	8/30	9/30	10/30	11/30	12/30	13/30	14/30	15/30	16/30	17/30	18/30	19/30	20/30	21/30	22/30	23/30	24/30	25/30	26/30	27/30	28/30	29/30	30/30	31/30	1/31	2/31	3/31	4/31	5/31	6/31	7/31	8/31	9/31	10/31	11/31	12/31	13/31	14/31	15/31	16/31	17/31	18/31	19/31	20/31	21/31	22/31	23/31	24/31	25/31	26/31	27/31	28/31	29/31	30/31	31/31	1/32	2/32	3/32	4/32	5/32	6/32	7/32	8/32	9/32	10/32	11/32	12/32	13/32	14/32	15/32	16/32	17/32	18/32	19/32	20/32	21/32	22/32	23/32	24/32	25/32	26/32	27/32	28/32	29/32	30/32	31/32	1/33	2/33	3/33	4/33	5/33	6/33	7/33	8/33	9/33	10/33	11/33	12/33	13/33	14/33	15/33	16/33	17/33	18/33	19/33	20/33	21/33	22/33	23/33	24/33	25/33	26/33	27/33	28/33	29/33	30/33	31/33	1/34	2/34	3/34	4/34	5/34	6/34	7/34	8/34	9/34	10/34	11/34	12/34	13/34	14/34	15/34	16/34	17/34	18/34	19/34	20/34	21/34	22/34	23/34	24/34	25/34	26/34	27/34	28/34	29/34	30/34	31/34	1/35	2/35	3/35	4/35	5/35	6/35	7/35	8/35	9/35	10/35	11/35	12/35	13/35	14/35	15/35	16/35	17/35	18/35	19/35	20/35	21/35	22/35	23/35	24/35	25/35	26/35	27/35	28/35	29/35	30/35	31/35	1/36	2/36	3/36	4/36	5/36	6/36	7/36	8/36	9/36	10/36	11/36	12/36	13/36	14/36	15/36	16/36	17/36	18/36	19/36	20/36	21/36	22/36	23/36	24/36	25/36	26/36	27/36	28/36	29/36	30/36	31/36	1/37	2/37	3/37	4/37	5/37	6/37	7/37	8/37	9/37	10/37	11/37	12/37	13/37	14/37	15/37	16/37	17/37	18/37	19/37	20/37	21/37	22/37	23/37	24/37	25/37	26/37	27/37	28/37	29/37	30/37	31/37	1/38	2/38	3/38	4/38	5/38	6/38	7/38	8/38	9/38	10/38	11/38	12/38	13/38	14/38	15/38	16/38	17/38	18/38	19/38	20/38	21/38	22/38	23/38	24/38	25/38	26/38	27/38	28/38	29/38	30/38	31/38	1/39	2/39	3/39	4/39	5/39	6/39	7/39	8/39	9/39	10/39	11/39	12/39	13/39	14/39	15/39	16/39	17/39	18/39	19/39	20/39	21/39	22/39	23/39	24/39	25/39	26/39	27/39	28/39	29/39	30/39	31/39	1/40	2/40	3/40	4/40	5/40	6/40	7/40	8/40	9/40	10/40	11/40	12/40	13/40	14/40	15/40	16/40	17/40	18/40	19/40	20/40	21/40	22/40	23/40	24/40	25/40	26/40	27/40	28/40	2
------	------	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	---



My Admission Record



N
712726128
SULLIVAN
Deborah F
07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital: GR1 Ward: SAU
Date of Admission: 12/1/25 Time: 01.40
Information obtained from: Name:
Patient ☒ Relative ☐ Other ☐
Preferred Name:
Age: 52 Telephone Number: 07713718392
Consultant: prof A mackay

Urine: glucose 1pH/5g
sent 12/1/25

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☒
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☒
Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact

Name: Robert glass
Relationship: Partner
Address:
Telephone: 07597389233
Is this person aware of your admission?
Yes ☒ No ☐
Can we share information with this person?
Yes ☒ No ☐

Preferred second contact

Name:
Relationship:
Address:
Telephone:
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Presenting Complaint / Diagnosis

Urinary symptoms 2/52
Explained to the patient? Yes ☒ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☒ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ Penicillin

Relevant past medical history

Appendectomy PTSD Delayed gastric emptying
fibromyalgia T2DM - on insulin
Pancreatitis 2°gs HTN

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☒ If yes, Who asked for a copy? _____
Date they asked for a copy ___/___/___ Date Obtained ___/___/___

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47**Carbapenemase-producing enterobacteriaceae (CPE)**

Have you ever:

1. Been an inpatient in a hospital outside Scotland?
2. Received holiday dialysis outside Scotland?
3. Been told that you have CPE?
4. Been in close contact with a person with CPE?

Yes	No
☐	☒
☐	☒
☐	☒
☐	☒

If the answer is yes to **ANY** of the questions in this section, you mustIsolate the patient in a side room ☐Obtain Rectal swab marked 'for CPE' ☐If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' and inform the IPCT ☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours.

Yes	No	Unsure
☐	☒	☐

If **YES** complete the following section

1. Have you ever been told that you have MRSA?
2. Have you been admitted from another hospital/ residential setting or care home?
3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐	☒	☐
☐	☒	☐
☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes	No	Unsure
☐	☒	☐

If **YES** inform the IPCT ☐


 0712726128 F
 SULLIVAN
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire G34 9JE
 18000 0000 0000 0000 0000 0000 0000 0000

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☐ when did you stop? _____

Never smoked ☐

Do you use eCigarettes? Yes ☒ No ☐

If a smoker, the NHSGCC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGCC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals.

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA); complete FAST Tool and take further action as per guidance.

Name (Please PRINT): CHEUSEA MCCABE

Signature: C. McCabe

Designation: SIN

Date: 12/1/25

My Assessment Record

N 

A0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
C G34 9JE
A

1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes	No	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?	✓	✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team?			
Contact details:			


 0712726128
 SULLIVAN
 Deborah
 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 G34 9JE

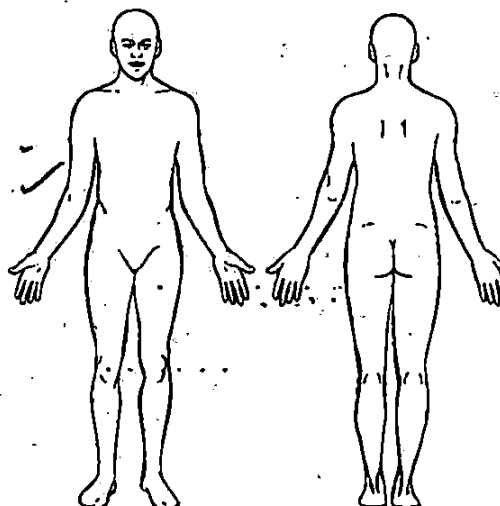
3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?			
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



**N.B. Complete generic pain assessment chart.
If unable to self report complete Abbey
Pain Scale.**

Can you describe any chronic pain that you have?

What makes the pain better?

	
0712726128	
SULLIVAN	F
Deborah	07/12/1972
Flat 0-1, 8 Boyndie Street	
Easterhouse	
Glasgow, Lanarkshire	
G34 9JE	

4. Cognitive Status

THINK DELIRIUM

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Nil

What do you like to eat and drink?

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	N  A 0712726128 SULLIVAN Deborah 07/12/1972 F Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE C A
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			Assessment of the patient's hydration and nutrition needs
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems		✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention	✓		

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	 0712726128 SULLIVAN Deborah 07/12/1972
Haematuria			
Incontinent			

N.B. If new Incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) In-situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? 11/1/25

How often in a day/week do you have a bowel movement? Per day Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☒

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular		✓	
Constipated			
Diarrhoea / loose stools	✓		
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. If concerned about bowel patterns (e.g. Infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma.
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

Name:  _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 (Glasgow, Lanarkshire G34 9JE

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

11. Social Circumstances				
Do you:				
Live alone	☒	Live with family/ friend/ other	☐	
Live in a nursing home	☐	Live in a care home	☐	
Live in residential supported care	☐	Live in student accommodation	☐	
Live in 'homeless' accommodation	☐	Have no fixed abode	☐	
Other please specify _____			☐	
Dependants			Yes ✓	No ✓
Do you have any dependants?				✓
Do you support anyone (e.g. partner, children, relatives, animals)?				✓
Do they need support from someone else whilst you are in hospital?				✓
Would someone else be able to provide this support when you are in hospital? If yes, who?				✓
If no support available contact Duty Social Worker				
Duty Social Worker Required ☐ Not required ☒ Referred ☐				
Services			Yes ✓	No ✓
Do you have support from social work, social services or a care package?				✓
If yes, please provide details:				
If yes, has contact been made to cancel arrangements during admission?				
12. Emotional and Spiritual Care				
Do you have a religion or beliefs that we can help you observe while you are in hospital?				
N/A				
Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital. (e.g. prayer meditation)?				
Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒				
Healthcare Chaplain informed Yes ☐ N/A ☒				

	
0712726128	
SULLIVAN	F
Deborah	07/12/1972
Flat 0-1, 8 Boyndie Street	
Easterhouse	
Glasgow, Lanarkshire	
G34 9JE	
Annex patient ID number	

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting Better

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

Partner

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

~~N/A~~

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐



0712726128

SULLIVAN

Deborah

07/12/1972

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐No ☒Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐No ☒

Are you:

Employed ☐Unemployed ☒Self-employed ☐Retired ☐Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐No ☒Not applicable ☐

Do you have any money worries?

Yes ☐No ☒Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐No ☒

If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐No ☒Not applicable ☐Not appropriate to ask at this time ☐

If yes when was patient referred ____/____/____

N
A0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
D Easterhouse
Glasgow, Lanarkshire
G34 9JE
C
A

Risk Assessments/Other Documentation

Additional NHSGCC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓		✓	
Generic Pain Scale Assessment Chart	✓		✓		Cm McCabe
Abbey Pain Scale (if unable to self report pain)		✓		✓	
4AT and TIME for Detection, Management and Prevention of Delirium		✓		✓	
Getting to Know Me – Relatives to complete		✓		✓	
What Matters to Me	✓		✓		Cm McCabe
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓		✓	
Malnutrition Universal Screening Tool (MUST)	✓		✓		Cm McCabe
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓		✓	
Bristol Stool Chart		✓		✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		Cm McCabe
Adult Wound Assessment and Management Chart		✓		✓	
Moving and Handling Assessment	✓		✓		Cm McCabe
Falls Risk Assessment	✓		✓		Cm McCabe
Bedrail Risk Assessment		✓		✓	

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
12/1/25	Patient admitted to SAU	
01.45	With urinary symptoms 2/52	
	Urinalysis - glucose independent	
	Self Caring - News: 2 tachy	
	90, Bp 102/69. Sips tolerated.	S/no.
	Bm 8.7. Await senior rlv.	Cm McCabe

	
0712726128	
SULLIVAN	F
Jebrach	07/12/1972
Flat 0-1, 8 Boyndie Street	
Easterhouse	
Glasgow, Lanarkshire	
G34 9JE	

Clinical Notes (cont.)		
Date and Time	Notes	Print Name, Signature and Designation
12/1/25	News. 1 today 95. BM 9.0. 4 units Humulin I Given. Imp. Renal stone vs pyelonephritis Plan: CT/Cub PR diclofenac MSSU Monitor Bloods. —	SIN CmFche
12/1/25	A - news = 0	
14:20pm	B - charts updated	
0/5	C - CBG 10.3 mmols @ Lunchtime. Plan = MSSU + Ph/sq/glv Sent 12/1/25 Patient awaits CT/Cub Medics to liaise with urology.	Shakeena CmFche
	D - nil —	Sr
16:10pm	Patient now away for CT/Cub await results —	Shakeena Sr
18:15	W/R Bladder scan @ 16mls ? Retention. ? clot. ? Home medical notes vacant	CmFche 2

[illegible]

Write or affix label  3712726128 SULLIVAN Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire. G34 9JE	Peripheral Venous Cannula (PVC) Insertion & maintenance Please complete insertion details for each PVC inserted Care & maintenance to be undertaken & documentation completed twice each day.	Modified Visual Infusion Phlebitis (VIP) Score	
		PVC site appears healthy	0 No phlebitis: Continue care and maintenance
		Either slight pain or redness near site	1 Possible first signs: Observe PVC site
		Two or more: pain / redness / swelling	2 Early stage of phlebitis: Remove and resite PVC
		All: pain / redness / hardening of surrounding area	3 Phlebitis/thrombophlebitis: Remove and resite PVC
As above and including: palpable venous cord	4 Seek further advice		
As above and including: pyrexia	5		

Insertion details: Date: <u>12/1/25</u> (Day 1) Time: _____	Where inserted: ☐ ED ☐ Theatre ☐ ITU/HDU ☒ Ward <u>SAO</u> ☐ Unknown	Insertion site: ☐ Hand ☒ Arm Other _____	Side: ☒ Left ☐ Right	Size of cannula: ☐ 26G Purple ☐ 24G Yellow ☐ 23G Blue ☒ 20G Pink ☐ 18G Green ☐ 16G Grey ☐ 14G Orange	Inserted by: Print: _____ Signature: _____ Designation: _____		
Clinical indication: ☐ Diagnostics ☐ Resuscitation	☐ IV medications ☐ Fluids	☐ Transfusion					
Insertion criteria: Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No				
DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia. Justify the need for your patient to have a PVC using the DRIFT mnemonic. ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest? ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route? ✓ Fluids - Does the patient require IV fluids? Could this be switched to oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?			Signs of local or systemic infection <table border="0"> <tr> <td> Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness </td> <td> Systemic infection • Hypotension • Tachycardia • Pyrexia </td> </tr> </table>			Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic infection • Hypotension • Tachycardia • Pyrexia
Local infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic infection • Hypotension • Tachycardia • Pyrexia						

Adult IVOST Guidelines 	Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines IV → Oral Antibiotic Switch Therapy (IVOST) Guideline Review need for IV antibiotics daily Can antibiotic therapy be stopped? (eg: alternative diagnosis)? If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours Switch to oral when: a CLINICAL IMPROVEMENT in signs of infection eg: temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption) a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureus bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess. DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness Record the stop date on HEPMA		Paediatric IVOST Guidelines 
	If IVOST criteria met → Switch to oral Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures IF not responsive MICROBIOLOGY switch to oral as outlined below		



0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

F

07/12/1972

PVCs should be removed as soon as no longer clinically indicated.

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date _/_/	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP _____	VIP _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed _/_/

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:
--------------------	---	---------------------------------------	--	---	--------

Date: 12/1/25

Attach Addr

SULLIVAN
Deborah

07/12/1972

NHS
Greater Glasgow
and Clyde

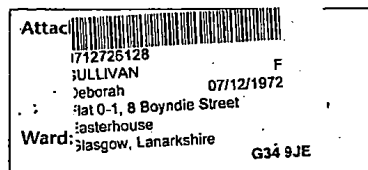
Ward:
SAU

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

[illegible]

Care Rounds Variance Sheet



NHS
Greater Glasgow
and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 3712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: CR1 Ward: SAU	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
---	----------------------------------	--

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
12/1/25	02:00	N	N	N	N	N	N	4 hrly	CmCabe
12/1/25	14:30	N	N	N	N	Y	Y	3 hrly	sn
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.



Attach Addressograph

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____



0712726128

SULLIVAN

Deborah

F
07/12/1972

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date <u>12/1/25</u> Time <u>01.50</u> of initial height and weight on admission to hospital		Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	<u>5' 9</u> cm	☐	☒	
Admission Weight	<u>91.30</u> Kg	☒	☐	

* Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☒ Don't Know ☐

Date	<u>12/1/25</u>						
Time	<u>01.50</u>						
Ward	<u>SAU</u>						
Oedema/ Ascites present Y/N	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>CH</u>						
Weight (kgs)	<u>91.30</u>						
BMI	<u>29.7</u>						

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on	<u>19/1/25</u>						
Signature	<u>CMC</u>						

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

NO

Is the patient's intake 'normal' or improved for them?

Complete the above steps

YES

NO

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

- Encourage higher calorie menu choices indicated with **O**
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

NO

Is the patient's intake 'normal' or improved for them?

Complete the above steps

YES

NO

Is the patient dying?

YES

NO

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

- Discontinue food and drink recording chart. Stop screening.
- Offer food and fluid as appropriate.

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Traicare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/Information-for-patients/food-in-hospital/discharge-from-hospital/



0712726128
SULLIVAN
Deborah 07/12/1972
Flat D-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: SAU Date: 12/1/25 Time: 01:50	Ward: SAU Date: 12/1/25 Time: 14:35	Ward: _____ Date: _____ Time: _____	Ward: _____ Date: _____ Time: _____	Ward: _____ Date: _____ Time: _____
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓	Complete			
2. Check walking aid (if required) is in reach and in use.	N/A	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓	available/ in room			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓	safe			
5. If glasses are worn, check they are available and in use.	✓ reading	available			
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

ALL patients in older people's wards must have an interventional plan in place (overleaf)

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			✓	✓							
2. Does the patient have cognitive impairment or a possible delirium?			✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓		✓						
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓		✓						
5. Based on your clinical judgement, is this patient at high risk of falling?			✓		✓						
Signature of nurse completing assessment / update		Amrae									

Highlight risk of fall at the ward safety brief.

0712726128
 SULLIVAN
 Deborah
 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire

FALLS INTERVENTION CHECKLIST

G34 9JE Complete for all patients identified at risk of falling.

Ward: SAN	Ward:	Ward:	Ward:	Ward:
Date: 12/1/25	Date:	Date:	Date:	Date:
Time: 14:35	Time:	Time:	Time:	Time:

BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	✓				
Assess if a low bed is required (Patient care plan 9)	✓				
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	✓				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	✓				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	N/A				
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	N/A				
Document continence problems and link to care rounding (Patient care plan 6)	N/A				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	N/A				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	N/A				
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	✓				
Update the ward team of the patient's mobility status. (Patient care plan 8)	✓				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	✓				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	✓				
Signature of nurse completing Interventional plan / or update	<i>[Signature]</i>				

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

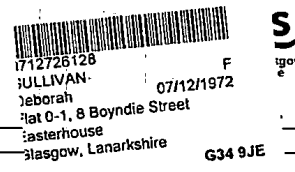
NHSGGC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name:

CHI Number:



Use guidance on the reverse of this document when completing this Risk Assessment	DATE	12/1/25
	TIME	14:20
	WARD	5A
	HOSPITAL	GH

SECTION ONE - GENERAL

1	Is the patient likely to fall, roll, slip or slide from the bed?	Y	N	Y	N	Y	N	Y	N
2	Has the patient requested the use of bedrails?	✓							

IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED

SECTION TWO - COGNITIVE AND PHYSICAL STATUS

3	Is the patient at risk of climbing out of bed?		✓						
4	Is the patient stressed, delirious or restless?		✓						
5	Is the patient small in stature?		✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓						

IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION THREE - COMMUNICATION

8	Has the patient been consulted regarding the use of bedrails?	✓							
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓							
10	Has the use of bedrails been discussed with relatives/carers?	✓							
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?	✓							
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?	✓							

IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf

SECTION FOUR - DECISION MAKING

13	Will bedrails be used for this patient at the present time?	Y	N	Y	N	Y	N	Y	N
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request	✓							
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:	87							
17	Date	12/1/25							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

**B. If bedrails are to be used, please consider the following:-
Is patient:-**

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

D. Record keeping:-**All of the following should be recorded:-**

- Date and time of assessment
- Bedrail information leaflet given to patient and/or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

Person Specific (Inpatient) Moving and Handling Assessment Form

		Named Nurse:		Person is totally independent (tick here and go to data box)	
0712726128 SULLIVAN Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE		Problems with comprehension, behaviour, co-operation (specify):			
91.30 BMI 28.1 cm		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):			
Risk of Falls: Yes No					
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)					
Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					
3. Toileting					
Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 2 >3	Additional Information:		
4. Move on / off bed pan					
Hoist	Manoeuvre	Assistance	Supervision	N / A	
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Independent bridging	People: 1 2 >3	Additional Information:		
5. Move up / down bed					
Hoist	Handling Aids	Assistance	Supervision	Independent	
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1 2 >3	Additional Information:		
6. Lateral Transfer to / from trolley / bed					
Hoist	Handling Aids	Assistance	Supervision	Independent	
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):		
7. Sit up over side of bed					
	Bed Rest	Assistance	Supervision	Independent	
		People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):		
8. Into Bath or Shower					
Equipment	Handling Aid	Assistance	Supervision	Independent	
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):		
Variable / Fixed height bath	Shower trolley				
Bed bath	Bathing hoist (eg Alens)				
9. Walking					
No Walking	Walking Aid	Assistance	Supervision	Independent	
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)		
10. Other Instructions / Observations / Equipment Used					
Recording Symbol:		1st Assessment	2nd Assessment	3rd Assessment	
Date Assessed:		Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star	
Assessor's signature:					
Proposed Review date:					

Continuation Sheet

[illegible]

1712726128
SULLIVAN
Jeborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Care Plan

Care discussed with patient Unable		☒ Yes ☐ No ☐	If unable, give reason:		
Care discussed with family Unable		☐ Yes ☐ No ☐	If unable, give reason:		
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
Cm ^{cc} 12/1	News as charted		Cm ^{cc} 12/1	Getting Better	
				5. Hydration and Nutrition	
			Cm ^{cc} 12/1	Normal D+f	
	2, 3. Communication and senses				
Cm ^{cc} 12/1	wears Reading glasses				
				6. Elimination	
	4. Cognitive status		Cm ^{cc} 12/1	Independent	
Cm ^{cc} 12/1	Alert + Orientated.				



07/12/1972

[illegible]

3712728128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G3 9JE

	Date	Ward	Time
Admitted	12/1/25	SAU	02:00
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96% Signature: _____ Print Name: _____ Dr/ANP initials ONLY: _____ Date: _____	SpO2 Scale 2 Target 88-92% Signature: _____ Print Name: _____ Dr/ANP initials ONLY: _____ Date: _____	Patient on home oxygen Y ☐ N ☐ If yes, add details of oxygen therapy
--	---	--

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response In Medical Notes	ACE Response In Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed _____

Medical: _____

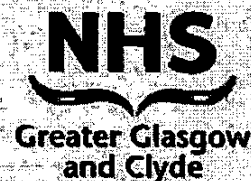
Date: _____

[illegible]

Patient name ...

Patient CHI ...

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE



R202 PAID

Emergency Care Nursing Documentation

Initial Investigations

Patient prepared for exam - clothing bagged				☒	☐
NEWS Chart	☒	☐	X-rays	☐	☐
ID band	☒	☐	Pain Score	☐	☐
Peak Flow	☐	☒	Please specify		
12-lead ECG	☐	☐	Urinalysis	☐	☐
IV access	☒	☐	Positive findings		
Blood samples	☒	☐			
Blood Gas	☐	☐			
B-HCG				☐	☐

Signature:

Communication

GGC Red Bag with Patient (nursing home resident)	☐	☒
Language or hearing difficulty	☐	☒
Interpreter required	☐	☒
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☐	☒
name, relationship, location, particular concerns		

Signature:

Risk Assessments and Screening Tools

SEPSIS	☐	☒	GMAWS	☐	☒
FAST	☐	☒	Adult Support and Protection	☐	☒
Time: Swallow Testing	☐	☒	Mental Health Triage Assessment	☐	☒
Falls Risk (clinical judgement)	☐	☒	Child Protection Concerns	☐	☒
4AT Assessment	☐	☒	Frailty Assessment	☐	☒
			Public Protection (NOC)	☐	☒

Signature:

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	☐	☐
Relatives / Carer with Patient	☐	☐
Name Band	☐	☐
Risk Assessment/Screening Tools	☐	☐
Bed Available	☐	☐
SBAR complete	☐	☐
NEWS Chart NEWS completed within 1 hour of transfer/discharge	☐	☐
Prescriptions and fluid charts signed	☐	☐
Cannula	☐	☐
Notes Complete	☐	☐
Analgesia	☐	☐
Belongings	☐	☐
Transport	☐	☐

Signature:



Patient name

Patient CHI

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

NHS
Greater Glasgow
and Clyde

Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr 4hr

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times																
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.																
	2	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If yes inform registered nurse.																
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU = Pressure Ulcer INT = Intact M = Moisture																
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand																
		ELIMINATION Does the patient need the toilet?																
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)																
N	6	FOOD FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplements taken? Has oral hygiene been carried out as per care plan?																
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?																
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return																
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return																
Care provider																		
Role																		

Ask the patient if there is anything they specifically want done today:



Patient name

Patient CHI

or use sticker



Nursing notes cont.

Date and Time

Name/Signature

Patient name

Patient CHI

or use sticker

Hospital:

Ward:

Points to consider:

- Use within 8 hrs of admission to care area
- Re-assess daily and more frequently if a person's condition changes



PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.
----------	------------------------	---

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score > 2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

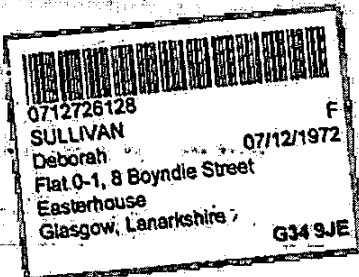
Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas _____ hourly • Skin under medical devices _____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition _____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning _____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out _____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/carer YES / NO

Patient name

Patient CHI



Nursing notes

Date and Time

Name/Signature

3/12/24

Abdo pain and vomiting
NEWS 1. Allocated cyclide,
awaits medical review
Bloods and IV access IV
analgesia and anti-emetic
given as charted

R/L (80)

20.05

Pt Given ATREMETIC. CONTINUED TO
WAIT FOR SURGICAL BED

SPGJSD

Patient name

Patient CHI

or use sticker



Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS, PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

My Admission Record



Hospital: GRI W63 Ward: 63
 Date of Admission: 3/12/24 Time: 2230
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐ _____
 Preferred Name: _____
 Age: 51 Telephone Number: 07713718392
 Consultant: Stevenson

Name: _____
 Add: _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boydrie Street
 DoF Easterhouse
 CHI Glasgow, Lanarkshire
 Affi _____ G34 9JE

none - please

Communication

What is your first language? English
 Do you require an interpreter? Yes ☐ No ☒
 If yes, provide details of arrangements made _____
 Do you use British Sign Language (BSL)? Yes ☐ No ☒
 Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact	Preferred second contact
Name: <u>Robert Glass</u> Relationship: <u>Boyfriend</u> Address: <u>19 Wymms Garden</u> <u>Barthelston</u> Telephone: <u>07597389233</u> Is this person aware of your admission? Yes ☒ No ☐ Can we share information with this person? Yes ☒ No ☐	Name: _____ Relationship: _____ Address: _____ Telephone: _____ Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Abdo pain + Vomiting
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ Penicillin

Relevant past medical history

Pancreatitis secondary to Gallstone, T2DM (Insulin),
cholecystectomy, Appendectomy,
funduplication for GERD
HFTN
ventricular hypertrophy
? Chronic pancreatitis @ pancreas 22
 On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
 Yes ☐ No ☒ If yes, Who asked for a copy? _____
 Date they asked for a copy ____/____/____ Date Obtained ____/____/____

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for: Finance ☒ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian _____

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47**Carbapenemase-producing enterobacteriaceae (CPE)**

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

☐☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

☐☒If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

☐**and inform the IPCT**☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes

No

Unsure

☒☐☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes

No

Unsure

☐☒☐If **YES** inform the IPCT ☐

Name: _____
Address: _____
0712726128
SULLIVAN
Deborah
07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
DoB: _____
CHI: _____
Affix pa: _____ G34 9JE

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☒ when did you stop? _____

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): B. WONG

Signature: B Wong

Designation: 3/12/24

Date: 3/12/24

My Assessment Record

Name _____
 Address _____
 0712728128
 SULLIVAN F
 Deborah 07/12/1972
 DoB: Flat 0-1, 8 Boyndie Street
 Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix: G34 9JE

1. Breathing and Circulation			
Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers.			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			
2. Communication			
	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?			
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team?			
Contact details: _____			

Name:  -
 Address: 0712726128 -
 SULLIVAN F -
 Deborah 07/12/1972 -
 Flat 0-1, 8 Boyndie Street -
 DoB: Easterhouse -
 CHI: Glasgow, Lanarkshire -
 Affix pa G34 9JE -

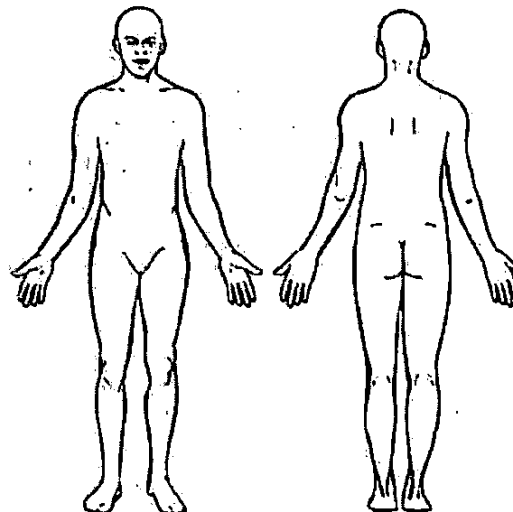
3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?			
Do you have your lenses with you?			
Do you wear a prosthesis?		✓	
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?			

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



**N.B. Complete generic pain assessment chart.
 If unable to self report complete Abbey
 Pain Scale.**

Can you describe any chronic pain that you have?

What makes the pain better?

Name: 
 Address: 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boydrie Street
 DoB: Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix patient label G34 9JE

4. Cognitive Status

THINK DELIRIUM

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	/	/	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

No

What do you like to eat and drink?

Water.
No fussy.

What do you not like to eat and drink?

No fussy

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation	Normal for the patient	Name: _____ Address: _____ 0712726128 SULLIVAN Deborah Date: 07/12/1972 CHI Affi: _____
Normal diet and fluids	☒	☒	
Therapeutic diet	☐	☐	Assessment of the patient's hydration and nutrition needs
Cultural, ethnic or religious diet	☐	☐	
Texture Modified Diet Please state _____	☐	☐	
Thickened Fluid Please state _____	☐	☐	
Oral Nutritional supplements Preferred flavour _____	☐	☐	
Enteral Nutrition	☐	☐	
Parenteral Nutrition	☐	☐	
Nil by Mouth	☐	☐	
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking			
Independent (Green)	☒	☒	
Prompting / encouragement / opening packets/cutting up food (Amber)	☐	☐	
Full assistance with eating and drinking (Red)	☐	☐	
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	☒	☒	
Frequently pass urine during the day	☐	☐	
Frequently pass urine overnight	☐	☐	
Sense of urgency when need to pass urine	☐	☐	
Urine retention	☐	☐	

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: _____ 0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire DoB: _____ CHI: _____ Affix passport photo 07/12/1972 G34 9JE
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☐ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGCC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

yesterday

How often in a day/week do you have a bowel movement? Per day ☒ Per week ☐

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. If concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?			
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

Name: _____
 Address: _____

 DoB: _____
 CHI: _____
 Affix patient ID label

7 Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems		✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Narr Addr
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management			 0712726128 SULLIVAN Deborah 07/12/1972 DoB: CHI: Affix

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

N.B. If not fully mobile and Independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?			

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		take Mirtazapine
Do you do or use anything to help you sleep?	✓		

Name	
Address	0712726128 SULLIVAN Deborah
DoB:	07/12/1972
CHI:	
Affix	

11. Social Circumstances

Do you:

Live alone	☒	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify _____ ☐			

Dependants

	Yes	No
Do you have any dependants?		☒
Do you support anyone (e.g. partner, children, relatives, animals)?		
Do they need support from someone else whilst you are in hospital?		
Would someone else be able to provide this support when you are in hospital? If yes, who?		
If no support available contact Duty Social Worker Duty Social Worker Required ☐ Not required ☐ Referred ☐		

Services

	Yes	No
Do you have support from social work, social services or a care package?		☒
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

No

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☐

Healthcare Chaplain informed Yes ☐ N/A ☐

Narr	_____
Add	_____
	0712728128
	SULLIVAN
	Deborah
	07/12/1972
DoB	Flat 0-1, 8 Boyndie Street
CHI	Easterhouse
	Glasgow, Lanarkshire
Affix	G34 9JE

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Feeling better & Home

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

Family

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐

Na _____
 Ad _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Do _____
 CH _____
 Affi _____

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☐

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐
 Self-employed ☐ Retired ☐
 Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ____/____/____

Name:

Address

0712726128

SULLIVAN

Deborah

07/12/1972

DoB: Flat 0-1, 8 Boyndie Street

CHI: Easterhouse

Glasgow, Lanarkshire

Affix pa

G34 9JE

Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
IAT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓		✓		
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓		✓		
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
3/10/24 BW 22:30	Patient transferred from A&E with Abdominal pain radiating through to back. Associated vomiting. Await to be reviewed urgently	BW [Signature]
4/10/24	Reviewed by medical staff	
02.41	Imp? delayed gastric emptying	
	Plan: get CT from NW reported if update.	

Name: _____
 Address: 
 0712726128
 SULLIVAN
 Deborah
 DoB: _____
 CHI: _____
 Affix pa _____

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
4/12/24	- Analgesia	
(cont)	- IV fluids.	
	W fluids running. Analgesia given. no concerns.	Gunn BME
06:45	also gave Analgesia given.	Gunn BME
	Remains on fire at present.	Gunn BME
4/12/24	Patient settled throughout day. meds given as per Hepma news as charted.	
16:16	Tolerating diet + fluids.	
	Bms checked throughout day as Diabetic. self administers insulin.	
	PRN pain Relief given.	
	NO new issues.	D Long RN
0:30	NEWS=2 due SpO ₂ =96% RA, BP↓. BM=8.4. Medications given as per Hepma. Analgesia given as per Hepma. Passing urine spontaneously.	
	Settled night so far.	Gunn BME / M. C. RANOLUA
5/12/24	Patient seen by MEDICS on	
0930	ward round. D/C HOME WITH OP CT. NO PVC.	
	MEDICATION SELF-ADMINISTERED FROM DOSET BOX INSULIN WASNT PRESCRIBED AT TIME. PATIENT DID NOT WANT TO WAIT AND SAID	

G34 8J1

Date: 3/12/24

1. Signed: BWONG. Name BWONG. Designation SIN.

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach A



0712726128

SULLIVAN

Deborah

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

Ward:

G349J

NHS
Greater Glasgow
and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9J	Hospital: GRI Ward: 63	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
1 Pressure Damage ☒ NO Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.		

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
3/12/24	22:30	N	N	N	N	N	N	4 hrly	BW
4/12/24	00:30	N	N	N	N	N	N	4 hrly	GB
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan



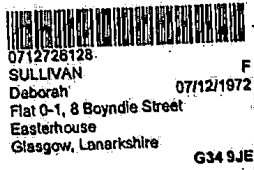
Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effective work practices in line with SSKINS bundle.

0712728128
SULLIVAN
Deborah
Flat 0-1, 8 Boydell Street
Easterhouse
Glasgow, Lanarkshire

G34 8JE

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	SELF MANAGEMENT / SHARED CARE	Signature / Comments
Date of plan:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree plan with patient / family / carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	 Date discontinued: _____
Date Reviewed:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	 Date discontinued: _____
Date Reviewed:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	 Date discontinued: _____



FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

Ward: 63	Ward:	Ward:	Ward:	Ward:
Date: 03/12/24	Date:	Date:	Date:	Date:
Time: 20:20	Time:	Time:	Time:	Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Y			
2. Check walking aid (if required) is in reach and in use.	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Y			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Y			
5. If glasses are worn, check they are available and in use.	Y			
6. If hearing aid/s are worn, check they are working and in use.	N			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		/								
5. Based on your clinical judgement, is this patient at high risk of falling?		/								
Signature of nurse completing assessment / update	B Wong									

Highlight risk of fall at the ward safety brief.



0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

07/12/1972

G34 9JE

FALLS INTERVENTIO CHECKLIST



Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time:	Time:	Time:	Time:	Time:

complete for all patients identified at risk of falling.

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					

SAFETY

Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					

HEALTH

Complete / Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan - negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Person Specific (Inpatient) Moving and Handling Assessment Form

Person's Name:	0712726128 SULLIVAN	Named Nurse:	W63	Person is totally independent (tick here and go to data box)	☒
1. Ge	Deborah	07/12/1972	blems with comprehension, behaviour, co-operation (specify):		
We	Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE				
BMI		cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):		
Risk of Falls:	Yes	No			
2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)					
Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					
3. Toileting					
Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 2 >3	Additional Information:		
4. Move on / off bed pan					
Hoist	Manoeuvre	Assistance	Supervision	N/A	
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Independent bridging	People: 1 2 >3	Additional Information:		
5. Move up / down bed					
Hoist	Handling Aids	Assistance	Supervision	Independent	
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1 2 >3	Additional Information:		
6. Lateral Transfer to / from trolley / bed					
Hoist	Handling Aids	Assistance	Supervision	Independent	
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):		
7. Sit up over side of bed					
	Bed Rest	Assistance	Supervision	Independent	
		People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):		
8. Into Bath or Shower					
Equipment	Handling Aid	Assistance	Supervision	Independent	
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):		
Variable / Fixed height bath	Shower trolley				
Bed bath	Bathing hoist (eg Nemo)				
9. Walking					
No Walking	Walking Aid	Assistance	Supervision	Independent	
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walker)		
10. Other Instructions / Observations / Equipment Used					
Recording Symbol:	1 st Assessment	2 nd Assessment	3 rd Assessment		
	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star		
Date Assessed:	3/12/24.				
Assessor's signature:	B Wong.				
Proposed Review date:	10/12/24.				



Continuation Sheet

[illegible]



0712728128
SULLIVAN
Deborah

07/12/1972

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date <u>3/12/24</u> Time <u>2230</u> of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>175</u> cm	☐	☒	
Admission Weight <u>95</u> kg	☐	☒	

* Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight ☐ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much ☐ No ☐ Don't Know ☐

Date	<u>3/12/24</u>	<u>3/12/24</u>					
Time	<u>22:30</u>	<u>22:30</u>					
Ward	<u>63</u>	<u>63</u>					
Oedema/ Ascities present Y/N	<u>N</u>	<u>N</u>					
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes		<u>UW</u>					
Weight (kgs)	<u>95</u>	<u>91.30</u>					
BMI	<u>31</u>	<u>29.8</u>					

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>	<u>0</u>					
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>	<u>0</u>					
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>	<u>0</u>					
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>	<u>0</u>					
Rescreen on	<u>10/12/24</u>	<u>10/12/24</u>					
Signature	<u>BS</u>	<u>BS</u>					

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
<u>0</u>	LOW RISK - Repeat screening every 7 days
<u>1</u>	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
<u>2 or greater</u>	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient / carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patient's choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with O
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

Complete the above steps

NO

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient / carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patient's choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Complete the above steps

NO

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Tracare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/



0712726128
SULLIVAN
Deborah
07/12/1972

Care Plan

Care discussed with patient Unable		☒ Yes	☐ No	☐ ?	If unable, give reason:	
Care discussed with family Unable		☐ Yes	☐ No	☐ ?	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me		Date discontinued & signature
3/12/24 BW	Frequency of SpO2 as per chart					
				5. Hydration and Nutrition		
			3/12/24 BW	N Diet & fluid as		
	2, 3. Communication and senses					
3/12/24 BW	able to communicate well with glasses for reading					
				6. Elimination		
	4. Cognitive status		3/12/24 BW	Independent		
3/12/24 BW	Alert & oriented					



0712726128
SULLIVAN
Deborah

07/12/1972 F

Care Plan

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
3/12/24 RL	Independent		3/12/24 RL	use shower when need help	
				10. Sleep and Rest	
			3/12/24 RL	private peaceful environment	
	8. Mobility				
3/12/24 RL	Independent			12. Privacy, dignity and sexuality	
			3/12/24 RL	Masked at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Date: 5/12/24

1. Signed Prasanna Name M. C. ANANDIA Designation SW
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

0712726128

07/12/1972

NHS
Greater Glasgow
and Clyde

63

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

No trials

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Date: 4.12.24.

1. Signed [Signature] Name [Name] Designation [Designation]
 2. Signed _____ Name _____ Designation _____
 3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Abstract

Ward:

G34 9JE

NHS
Greater Glasgow
and Clyde

[illegible]

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Fluid Balance Chart

Name:  0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: <u>GR1</u> Ward: <u>63</u> Date: <u>4/12/24</u>	Reason for Fluid Balance Chart <u>U/F</u> Is patient fluid restricted? Yes ☐ No ☒ If yes how many mls in 24 hours? _____ Fluid balance from previous 24hrs +/- _____	Does patient require thickened fluids? Yes ☐ No ☒ Stage _____ Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate: 1. Type _____ circle how many daily 1 2 3 2. Type _____ circle how many daily 1 2 3 Signature: <u>Bma</u> Designation: <u>RN</u>
---	---	---	---

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

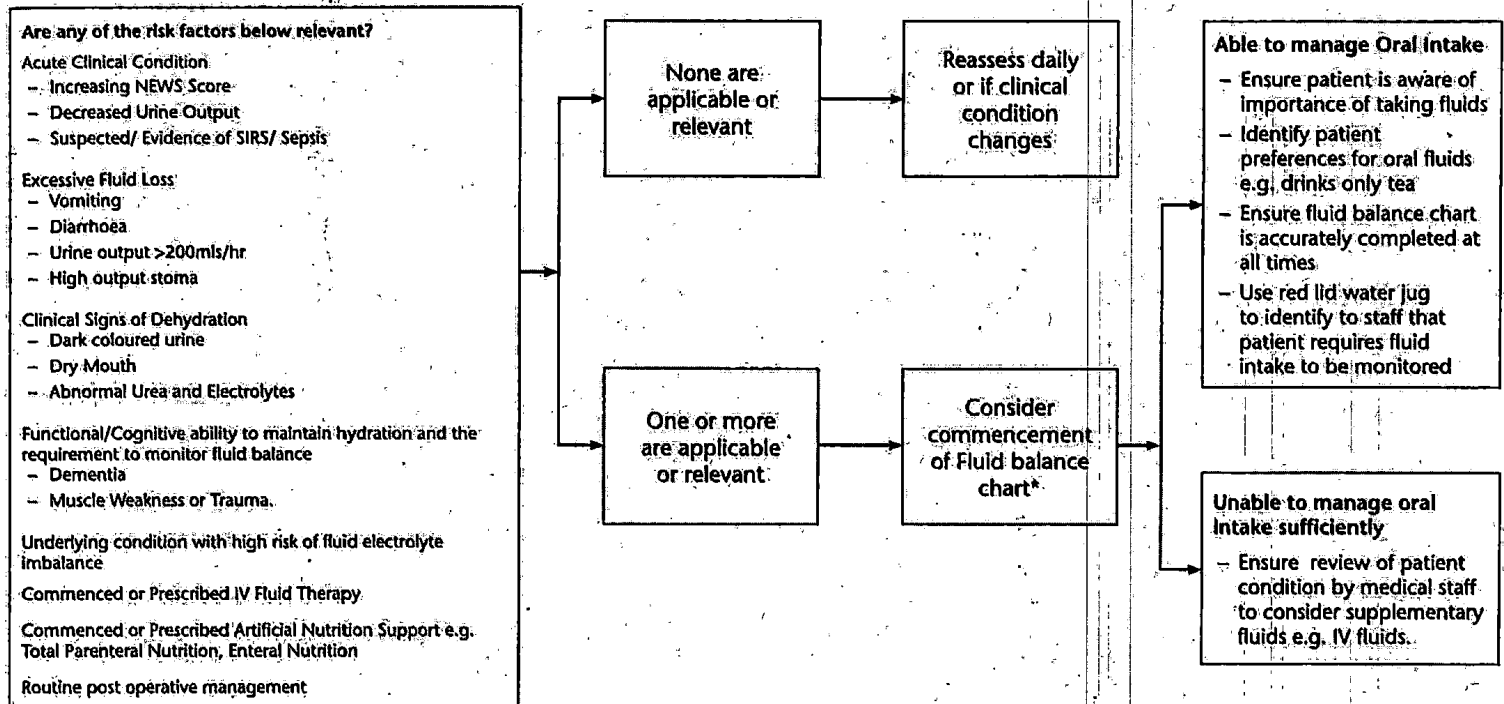
Time	Input								Running Total INPUT	Output			Running Total OUTPUT	Initials			
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel			Type	Type	Type
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00					IV	1000			1000								
02:00																	
03:00																	
04:00																	
05:00										PJ.							
06:00																	
07:00																	
08:00	water	250															
09:00																	
10:00	water	100															
11:00																	
12:00	water	150							800								
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
*Total Intake										*Total Output							

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

***24 hr Fluid
Balance +/-**

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

Write on affix label Na 0712728128 Ac SULLIVAN F Ct Deborah 07/12/1972 Dc Flat 0-1, 8 Boydla Street Easterhouse Hi Glasgow, Lanarkshire. G34 9JE		Peripheral Venous Cannula (PVC) Insertion & maintenance. Please complete insertion details for each PVC inserted Care & maintenance to be undertaken & documentation completed twice each day.		Modified Visual Infusion Phlebitis (VIP) Score	
PVC site appears healthy		0		No phlebitis: Continue care and maintenance	
Either slight pain or redness near site		1		Possible first signs: Observe PVC site	
Two or more: pain / redness / swelling		2		Early stage of phlebitis: Remove and resite PVC	
All: pain / redness / hardening of surrounding area		3		Phlebitis/thrombophlebitis: Remove and resite PVC	
As above and including: palpable venous cord		4		Seek further advice	
As above and including: pyrexia		5			

Insertion details: Date: 3/11/24 (Day 1) Time:	Where inserted: ☒ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown	Insertion site: ☒ Hand ☐ Arm Other:	Side: ☒ Left ☐ Right	Size of cannula: ☐ 26G Purple ☐ 24G Yellow ☒ 22G Blue ☐ 20G Pink ☐ 18G Green ☐ 16G Grey ☐ 14G Orange	Inserted by: Print: DV Signature: Designation:
---	--	---	---	---	---

Clinical indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S. aureus bacteraemia.		Signs of local or systemic infection	
Justify the need for your patient to have a PVC using the DRIFT mnemonic. ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest? ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route? ✓ Fluids - Does the patient require IV fluids? Could this be switched to oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?		Local Infection • Erythema / inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines IV → Oral Antibiotic Switch Therapy (IVOST) Guideline	
Review need for IV antibiotics daily Can antibiotic therapy be stopped? (e.g. alternative diagnosis)? If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours.	
Switch to oral when: - a CLINICAL IMPROVEMENT in signs of infection eg: temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, Improving SEPSIS - a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption) - a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureus bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess. DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness Record the stop date on HEPMA	
If IVOST criteria met → Switch to oral Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures If not responsive MICROBIOLOGY switch to oral as outlined below	





Name: SULLIVAN F.
Address: Daborah
CHI: Flat 0-1, 8 Boydla Street
DOB: Easterhouse
Hospita: Glasgow, Lanarkshire G34 9J

PVCs should be removed as soon as no longer clinically indicated.

Maintenance - to be completed twice daily (Observe for signs and symptoms of local or systemic infection)														
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures, hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:	
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night		
Day 1 Insertion Date 03/12/24	☒ Yes ☐ No	☐ Yes ☐ No	VIP <u>D</u>	VIP <u> </u>	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	Day <u>BW</u> Night <u> </u>		
Day 2 14/12/24	☒ Yes ☐ No	☐ Yes ☐ No	VIP <u>0</u>	VIP <u> </u>	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u>M</u> Night <u> </u>			
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u> </u>	VIP <u> </u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u> </u> Night <u> </u>			
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u> </u>	VIP <u> </u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u> </u> Night <u> </u>			
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u> </u>	VIP <u> </u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u> </u> Night <u> </u>			
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u> </u>	VIP <u> </u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u> </u> Night <u> </u>			
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP <u> </u>	VIP <u> </u>	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day <u> </u> Night <u> </u>			
PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed 0 / /														
Reason for removal			☐ Site Infection			☐ Infiltration			☐ Extravasation			End of treatment		Other: 0

634 91E

[illegible]

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart.

Think ACE	
A	Action: Working diagnosis (consider SEPSIS): Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

0112126128
SULLIVAN
Deborah
Flat 0-1, 8 Boydrie Street
Eastertown
Glasgow, Lanarkshire

07/12/1972

 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	
---	--

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96% Signature: _____ Print Name: _____ Dr/ANP initials ONLY: _____ Date: _____	SpO2 Scale 2 Target 88-92% Signature: _____ Print Name: _____ Dr/ANP initials ONLY: _____ Date: _____	Patient on home oxygen Y ☐ N ☐ If yes, add details of oxygen therapy
---	---	--

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes.

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed:

Medical:

Date:

Deborah Sullivan

[illegible][illegible]SpO2 Scale 1
Oxygen saturation (%)[illegible][illegible][illegible][illegible][illegible]

Abbreviations for recording oxygen device

A	Room Air
N	Nasal Cannula
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RAI	Reservoir Mask (emergency use only)

[illegible]

Pupil Size (mm)

1 2 3 4 5 6 7 8

No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

A	No limitations; activity unrestricted by pain or settles quickly	
B	Mild limitations, mild activity restrictions	
C	Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice	
D	Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required	

Patient n: 
 0712725128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 G34 9JE



Emergency Care Nursing Documentation *ABDO PAIN*

Initial Investigations					
Patient prepared for exam - clothing bagged				☒ Y	☐ N
NEWS Chart	☒ Y	☐ N	X-rays	☐ Y	☐ N
ID band	☐ Y	☐ N	Pain Score	☐ Y	☐ N
Peak Flow	☐ Y	☐ N	Please specify		
12-lead ECG	☐ Y	☐ N	Urinalysis	☐ Y	☐ N
IV access	☐ Y	☐ N	Positive findings		
Blood samples	☐ Y	☐ N			
Blood Gas	☐ Y	☐ N			
				B-HCG	☐ Y ☐ N
Signature:					

Communication		
GGC Red Bag with Patient (nursing home resident)	☐ Y	☐ N
Language or hearing difficulty	☐ Y	☐ N
Interpreter required	☐ Y	☐ N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☐ Y	☐ N
name, relationship, location, particular concerns		
Signature:		

Risk Assessments and Screening Tools							
SEPSIS		☐ Y	☐ N	GMAWS		☐ Y	☐ N
FAST		☐ Y	☐ N	Adult Support and Protection		☐ Y	☐ N
Time:	Swallow Testing	☐ Y	☐ N	Mental Health Triage Assessment		☐ Y	☐ N
Falls Risk (clinical judgement)		☐ Y	☐ N	Child Protection Concerns		☐ Y	☐ N
4AT Assessment		☐ Y	☐ N	Frailty Assessment		☐ Y	☐ N
				Public Protection (NOC)		☐ Y	☐ N
Signature:							

Pause for Discharge or Transfer		
GGC Red Bag with Patient (nursing home resident)		☐ Y ☐ N
Relatives / Carer with Patient		☐ Y ☐ N
Name Band		☐ Y ☐ N
Risk Assessment/Screening Tools		☐ Y ☐ N
Bed Available		☐ Y ☐ N
SBAR complete		☐ Y ☐ N
NEWS Chart NEWS completed within 1 hour of transfer/discharge		☐ Y ☐ N
Prescriptions and fluid charts signed		☐ Y ☐ N
Cannula		☐ Y ☐ N
Notes Complete		☐ Y ☐ N
Analgesia		☐ Y ☐ N
Belongings		☐ Y ☐ N
Transport		☐ Y ☐ N
Signature:		

Patient na

Patient CF

0712728128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 G34 9JE



Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr 4hr

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times																
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.																
	2	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If yes inform registered nurse.																
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU - Pressure Ulcer INT = Intact M = Moisture																
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand																
		ELIMINATION Does the patient need the toilet?																
I	5	I = Independent A - Assistance given IC = Incontinent (urine/faeces)																
N	6	FOOD FLUIDS AND NUTRITION Is the patient nil by mouth?																
		Drink taken?																
		Food, snack, or supplements taken?																
		Has oral hygiene been carried out as per care plan?																
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?																
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return																
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return																
Care provider																		
Role																		

Ask the patient if there is anything they specifically want done today:

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

Patient name

Patient CHI

or use sticker

Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes



PUDRA	
1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3 Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5 Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

te	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____hrly	
/ /	:							____hrly	
/ /	:							____hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name

Patient CHI

or use sticker



Ongoing Care									
	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS, PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient C

[illegible]

My Admission Record



Hospital: GR1 Ward: 63
 Date of Admission: 12/09/24 Time: 4:00
 Information obtained from: Name: _____
 Patient ☐ Relative ☐ Other ☐ _____
 Preferred Name: Debbie
 Age: 51 Telephone Number: 07713718392
 Consultant: Mv Gall

N
 A: 0712726128
 SULLIVAN
 Deborah 07112197
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 CI G34 9JL
 Af: _____

Urine ☐

Communication

What is your first language? English
 Do you require an interpreter? Yes ☐ No ☒
 If yes, provide details of arrangements made _____
 Do you use British Sign Language (BSL)? Yes ☐ No ☒
 Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact	Preferred second contact
Name: <u>Dona Sullivan</u> Relationship: <u>Sister</u> Address: _____ Telephone: <u>07743956178</u> Is this person aware of your admission? Yes ☒ No ☐ Can we share information with this person? Yes ☒ No ☐	Name: _____ Relationship: _____ Address: _____ Telephone: _____ Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Abdo pain
 Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ Penicillin (rash)

Relevant past medical history

- T2DM - Fibromyalgia - Chronic pancreatitis	- PID - HTN - GORD - cholecystectomy	- Appendicectomy - Fundoplication - Constipation
--	---	--

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
 Yes ☐ No ☒ If yes, Who asked for a copy? _____
 Date they asked for a copy ____/____/____ Date Obtained ____/____/____

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian _____

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Name:

Addr



0712726128

SULLIVAN

Deborah

07/12/197

DoB: Flat 0-1, 8 Boyndie Street

Easterhouse

CHI: Glasgow, Lanarkshire

Affix

G34 9J

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

☐☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

☐☐If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' and inform the IPCT

☐☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes

No

Unsure

☒☐☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes

No

Unsure

☐☒☐If **YES** Inform the IPCT ☐

Name:  0712726128
 Address: F SULLIVAN 07/12/1972
 2 Deborah Flat 0-1, 8 Boyndie Street
 DoB: Easternhouse
 CHI: Glasgow, Lanarkshire
 Affix p^E G34 9JE

Lifestyle

Smoking

vape

Are you a: smoker ☒ ex-smoker ☐ when did you stop? _____

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGCC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGCC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): MALGORZATA CZYŻANOWSKA Signature: *Czyżanowska*

Designation: SN

Date: 12/09/24

My Assessment Record

Name:

Age

0712726128

SULLIVAN

Deborah

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

CHI:

Affix

07/12/197

G34 9JL

1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest	✓	✓	
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes	No	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?	✓	✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team?			
Contact details:			

Name: 
 Address: 0712728128
 = SULLIVAN
 2 Deborah
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 DoB: 07/12/1977
 CHI: G34 8J1
 Affix patient ID label

B. Senses		
Vision	Yes ✓	No ✓
Do you have any problems with your vision?	✓	
Do you wear glasses?	✓	
Do you have your glasses with you?	✓	
Do you wear contact lenses?		✓
Do you have your lenses with you?		✓
Do you wear a prosthesis?		✓
Hearing	Yes ✓	No ✓
Do you have any problems with your hearing?		✓
Do you have any hearing loss?		
Do you use a hearing aid?		
Do you have your hearing aid(s) with you?		
Pain	Yes ✓	No ✓
Do you have pain?	✓	

Assessment of the patient's vision

Distance ☐ Reading ☒ Both ☐

Assessment of the patient's hearing

Assessment of the patient's pain

Can you describe where and what the pain is like?

stabbing pain

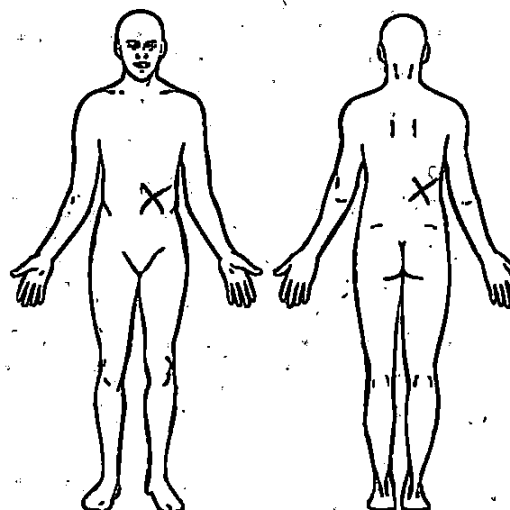
Mark current pain on body chart

Have you had treatment / intervention for the pain?

**N.B. Complete generic pain assessment chart.
If unable to self report complete Abbey
Pain Scale.**

Can you describe any chronic pain that you have?

What makes the pain better?



Name: _____
 Ad: 
 0712728128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boyndie Street
 DoE: Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix: G34 9J1

4. Cognitive Status

THINK DELIRIUM

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs.

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

No

What do you like to eat and drink?

likes most food

What do you not like to eat and drink?

N/A

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation	Normal for the patient	 0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JL
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			Assessment of the patient's hydration and nutrition needs
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission? 			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: _____ Address: _____ 0712726128 SULLIVAN DoB: 2 Deborah 07/12/197 CHI: _____ Affix pat: _____
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGCC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? today

How often in a day/week do you have a bowel movement? Per day 1 Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☒ Lactulose No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. If concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

Name: _____
 Address: _____
 F 0712726128
 SULLIVAN
 2 Deborah
 DoB: 07/12/1972 F
 CHI: _____
 Affi: _____

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name:  Address: 0712726128 SULLIVAN Deborah 07/12/197 DoB: _____ CHI: _____ Affix p: _____
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	stick - al have
Unsteady when walking			
Do you use a mobility aid	Yes ☒ No ☐		
Do you have your mobility aid with you?	Yes ☐ No ☒		

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		Diazepam
Do you do or use anything to help you sleep?	✓		

Nan	
Add:	0712726128
	SULLIVAN
	Deborah
DoB:	07/12/1977
CHI:	
Affix patient ID label	

11. Social Circumstances

Do you:

Live alone ☒	Live with family/ friend/ other ☐
Live in a nursing home ☐	Live in a care home ☐
Live in residential supported care ☐	Live in student accommodation ☐
Live in 'homeless' accommodation ☐	Have no fixed abode ☐
Other please specify ☐	

Dependants	Yes	No
Do you have any dependants?	☒	☒
Do you support anyone (e.g. partner, children, relatives, animals)? <i>cat</i>	☒	☐
Do they need support from someone else whilst you are in hospital?	☒	☐
Would someone else be able to provide this support when you are in hospital? If yes, who?	☒	☐
If no support available contact Duty Social Worker		
Duty Social Worker Required ☐ Not required ☒ Referred ☐		

Services	Yes	No
Do you have support from social work, social services or a care package?	☐	☒
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?	☐	☐

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?
Catholic

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed Yes ☐ N/A ☒

Name: _____
 Address: _____
 0712726128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 07112/197
 G34 9JE

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

get better

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

Daughter

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

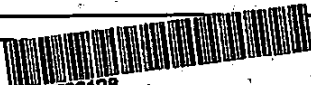
.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☒

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
 (please tick) Yes ☐ No ☒

N= 
 Ac 0712726128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boyndie Street
 Doi Easterhouse
 CHI Glasgow, Lanarkshire
 Affi G34 9JL

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Self-employed ☐

Full time education ☐

Unemployed ☒

Retired ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☒

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____/____/____

Risk Assessments/Other Documentation

Name: 
 A 0712726128
 SULLIVAN 07/12/197
 Deborah
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire G34 9JL
 Do CH Affix

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓		✓		Cyprus 12/9/24 M. C. PANOLSKA
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		Cyprus 12/9/24 M. C. PANOLSKA
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓		✓		Cyprus 12/9/24 M. C. PANOLSKA
Bedrail Risk Assessment					

Clinical Notes

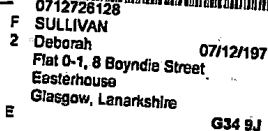
Date and Time	Notes	Print Name, Signature and Designation
12/9/24	Pt admitted to Hd 63 via A+E.	
4:50	Presented with abdo pain.	
	NGW = 0 BM = 11.6 Awaiting r/o.	Cyprus SN M. C. PANOLSKA
0930	WZ R-CTA/ET	
1140	All CAC as changed	
	taking AD	
	PJ	

Nar
Ad: 0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
07/12/197
G34 9JL

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Mobile	
	Obs @ Ness	
	Meds need prescribed	
	Insulin taken as prescribed	
	Own am meds taken as	
	pr has own dosette box	
	Await CTAPIT	Li(8)
13.9.24 0300	(A) - NEWS 2 to sets 4 HR. (B) - charts checked + updated. (C) - Independent + mobile. All meds as per hepna. PLAN analgesia given. Awaits CTAP.	
	(D) no new concerns. Settled	
	and sleeping @ present	Arulites
13/9/24 1055	WR: awaiting scan stop IVF	SN
13/9/24 1400	A - NEWS stable on charted B - checked up to date. C - vomited three today III cyclizine given for more antiemetics. Doctor will prescribe. RNS stable to monitor.	
	D - monitor ongoing vomits.	Glenn Hynes
1905	Have taken Covid test from pt. Await results.	SN

Affix patient ID label



Care Plan

[illegible]



Care discussed with patient Unable		☒ Yes	☐ No	☐	If unable, give reason:		
Care discussed with family Unable		☐ Yes	☒ No	☐	If unable, give reason:		
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me		Date discontinued & signature	
12/9/24 Czyzanski	Known RTN						
				5. Hydration and Nutrition			
			12/9/24 Czyzanski	Fasting for xlv.			
	2, 3. Communication and senses						
12/8/24 Czyzanski	No issues						
				6. Elimination			
	4. Cognitive status		12/8/24 Czyzanski	Continent			
12/8/24 Czyzanski	Orientated						

Date: 12/9/24

1. Signed C. J. 2012/01/11 Name M. C. 24/01/2012 Designation SW

2. Signed _____ Name _____ Designation _____

3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach Add

0712726128

F. SULLIVAN

2. Dehloran

07/12/197

NHS
Greater Glasgow
and Clyde

Ward
63

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

MO thank

[illegible]

Attach Addressograph Label	
----------------------------	--



1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

[illegible]

Date: 13/9/24

1. Signed [Signature] Name M. D. S. M. M. M. Designation Head
2. Signed [Signature] Name [Signature] Designation CA
3. Signed _____ Name _____ Designation _____

No Thank

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Date: 12/9/21

1. Signed M Das Main Name Hesw Designation Co
2. Signed Sonali Name Nicou Skou Designation SH
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach Ad

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire G34 8JE

Ward:

624

'Must do's' for me. Ask the patient if there is anything they want specifically done today:

no Thanky.

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Nan: 0712728128 Add: SULLIVAN CHI: Deborah DOB: Hosp:	Peripheral Venous Cannula (PVC) Insertion & maintenance Please complete insertion details for each PVC inserted Care & maintenance to be undertaken & documentation completed twice each day.	Modified Visual Infusion Phlebitis (VIP) Score	
		PVC site appears healthy	0 No phlebitis: Continue care and maintenance
		Either slight pain or redness near site	1 Possible first signs: Observe PVC site
		Two or more: pain / redness / swelling	2 Early stage of phlebitis: Remove and resite PVC
		All: pain / redness / hardening of surrounding area	3 Phlebitis/thrombophlebitis: Remove and resite PVC
As above and including: palpable venous cord		4	Seek further advice
As above and including: pyrexia		5	

Insertion details: Date: 12.9.24 (Day 1) Time:	Where Inserted: ☒ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown	Insertion site: ☐ Hand ☐ Arm Other: <u>Forearm</u>	Side: ☒ Left ☐ Right	Size of cannula: ☐ 26G Purple ☐ 24G Yellow ☐ 23G Blue ☒ 20G Pink	☐ 18G Green ☐ 16G Grey ☐ 14G Orange	Inserted by: Print: <u>A+E</u> Signature: Designation:
Clinical Indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids		☐ Transfusion.
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% Isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No		

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.		Signs of local or systemic infection	
Justify the need for your patient to have a PVC using the DRIFT mnemonic. ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest? ✓ Intravenous (IV) - Does the patient require Intravenous (IV) medication? Could these be switched to another route? ✓ Fluids - Does the patient require IV fluids? Could this be switched to oral fluids? ✓ Transfusion - Does the patient require a transfusion of blood products?		Local Infection • Erythema / Inflammation • Exudate • Hot to touch • Pain/tenderness	Systemic Infection • Hypotension • Tachycardia • Pyrexia

	Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines		
	IV → Oral Antibiotic Switch Therapy (IVOST) Guideline		
	Review need for IV antibiotics daily Can antibiotic therapy be stopped? (eg: alternative diagnosis)? If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours		
	Switch to oral when: a CLINICAL IMPROVEMENT in signs of infection eg: temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption) a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureus bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess. DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness Record the step date on HEPMA		
	If IVOST criteria met → Switch to oral Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures IF not responsive MICROBIOLOGY switch to oral as outlined below		

0712728128
 Name: SULLIVAN F
 Address: Deborah 07/12/1872
 Flat 0-1, 8 Boydla Street
 CH: Easterhouse
 Glasgow, Lanarkshire
 DOB: 31/01/1972
 Hospital: 1

PVCs should be removed as soon as no longer clinically indicated.



Maintenance - to be completed twice daily (Observe for signs and symptoms of local or systemic infection)													
Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 12/9/24	☐ Yes ☒ No	☒ Yes ☐ No	VIP	VIP	☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 1 25/09/2024 Day 11/10/24		
Day 2 13/9/24	☒ Yes ☐ No	☐ Yes ☒ No	VIP	VIP	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 2 26/09/2024 Day 12/10/24			
Day 3	☐ Yes ☒ No	☐ Yes ☒ No	VIP	VIP	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 3 27/09/2024 Day 13/10/24			
Day 4	☐ Yes ☒ No	☐ Yes ☒ No	VIP	VIP	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 4 28/09/2024 Day 14/10/24			
Day 5	☐ Yes ☒ No	☐ Yes ☒ No	VIP	VIP	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 5 29/09/2024 Day 15/10/24			
Day 6	☐ Yes ☒ No	☐ Yes ☒ No	VIP	VIP	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 6 30/09/2024 Day 16/10/24			
Day 7	☐ Yes ☒ No	☐ Yes ☒ No	VIP	VIP	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Left in situ ☒ Redressed ☐ Removed	☐ Left in situ ☒ Redressed ☐ Removed	Day 7 01/10/2024 Day 17/10/24			

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed: / /

Reason for removal: ☐ Site Infection ☐ Infiltration ☐ Extravasation ☐ End of treatment Other:

Pressure Ulcer Daily Risk Assessment (PUDRA)

 0712728128 F SULLIVAN 2 Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE E	Hospital: GRA Ward: 63	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
---	---	--

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
12/9/24	14:30	N	N	N	N	N	N	4 hrly	MC
13/9/24	08:00	N	N	N	N	N	N	4 hrly	Wright
14/9/24	02:30	N	N	N	N	N	N	4 hrly	Wright
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	
/ /	:							__ hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

NHS
Greater Glasgow
and Clyde

Attach Addressograph

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for Increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST:	• Discuss and agree plan with patient / family/ carer. YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for Increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for Increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

0712726128
F SULLIVAN
2 Deborah 07/12/1972

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date <u>12/8/24</u> Time <u>4:30</u> of initial height and weight on admission to hospital		Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition			
Admission Height	<u>5ft 9</u> <u>176</u> cm	☐	☐				
Admission Weight	<u>94</u> Kg	☐	☒ <u>weight lost in diabetic clinic</u>				
* Obtain accurate height/weight and rescreen as soon as possible							
Patients reported normal weight <u>99</u> Unable to Recall ☐							
Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☒ Don't Know ☐							
Date	<u>12/8/24</u>						
Time	<u>4:50</u>						
Ward	<u>63</u>						
Oedema/ Ascities present Y/N	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>N/A</u>						
Weight (kgs)	<u>94</u>						
BMI	<u>30</u>						
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days							
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on	<u>18/8/24</u>						
Signature	<u>MC</u>						
Step 5 Management Guidelines (excludes patients who are Nil by Mouth)							
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan						
<u>0</u>	LOW RISK - Repeat screening every 7 days						
<u>1</u>	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf						
<u>2 or greater</u>	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf						

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patient's choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ⓐ
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

Complete the above steps

NO

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patient's choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Complete the above steps

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Traicare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/Information-for-patients/food-in-hospital/discharge-from-hospital/

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 8JL

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 63 Date: 12/9/24 Time: 4:30	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓ independent				
2. Check walking aid (if required) is in reach and in use.	✓ stick not with pt				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓ to hand				
4. Check footwear is safe (refer to NHS GGC Footwear guidance).	✓ own shoes				
5. If glasses are worn, check they are available and in use.	✓ ready				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?	✓										
2. Does the patient have cognitive impairment or a possible delirium?			✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓								
5. Based on your clinical judgement, is this patient at high risk of falling?			✓								
Signature of nurse completing assessment / update		18/9/24									

Highlight risk of fall at the ward safety brief.



Ward: 63	Ward:	Ward:	Ward:	Ward:
Date: 12/9/24	Date:	Date:	Date:	Date:
Time: 4:30	Time: -----	Time: -----	Time: -----	Time: -----

Signature of nurse completing Interventional plan / or update

ch/pt
no leaflets

✓

✓

NIA

Ceylan
1818124

P

0712726128

SULLIVAN

Deborah

07/12/197

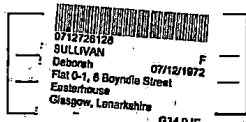
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

Patient) Moving and Handling Assessment Form

Person's Name:	Named Nurse:		Person is totally independent (tick here and go to data box)	☒																				
1. General																								
Body Build		Problems with comprehension, behaviour, co-operation (specify):																						
Weight	Height																							
Kg	cm																							
BMI		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):																						
Risk of Falls:	Yes	No																						
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)																								
Hoist	Standard	Walking Aid	Assistance	Supervision																				
Model		Aid Type	People: 1 2 >3	Independent																				
Sling type	Additional Information / Equipment																							
Sling Size																								
3. Toileting																								
Hoist	Standard	Walking Aid	Assistance	Supervision																				
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 2 >3	Additional Information:																					
4. Move on / off bed pan																								
Hoist	Manoeuvre	Assistance	Supervision	N/A																				
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 >3	Additional Information:																					
	Monkey pole																							
	Independent bridging																							
5. Move up / down bed																								
Hoist	Handling Aids	Assistance	Supervision	Independent																				
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 >3	Additional Information:																					
	Monkey pole																							
	Rope ladder																							
6. Lateral Transfer to / from trolley / bed																								
Hoist	Handling Aids	Assistance	Supervision	Independent																				
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):																					
	Other (Please specify)																							
7. Sit up over side of bed																								
	Bed Rest	Assistance	Supervision	Independent																				
		People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):																					
8. Into Bath or Shower																								
Equipment	Handling Aid	Assistance	Supervision	Independent																				
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):																					
Variable / Fixed height bath	Shower trolley																							
Bed bath	Bathing hoist (eg Alens)																							
9. Walking																								
No Walking	Walking Aid	Assistance	Supervision	Independent																				
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)																					
10. Other Instructions / Observations / Equipment Used																								
<table border="1"> <thead> <tr> <th></th> <th>1st Assessment</th> <th>2nd Assessment</th> <th>3rd Assessment</th> </tr> </thead> <tbody> <tr> <td>Recording Symbol:</td> <td>/ Forward slash</td> <td>X Where a forward slash exists, add a back slash to make a cross</td> <td>* Where a slash or cross exists add slashes to make a star</td> </tr> <tr> <td>Date Assessed:</td> <td>12/9/24</td> <td></td> <td></td> </tr> <tr> <td>Assessor's signature:</td> <td>Deborah Sullivan</td> <td></td> <td></td> </tr> <tr> <td>Proposed Review date:</td> <td>18/9/24</td> <td></td> <td></td> </tr> </tbody> </table>						1st Assessment	2nd Assessment	3rd Assessment	Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star	Date Assessed:	12/9/24			Assessor's signature:	Deborah Sullivan			Proposed Review date:	18/9/24		
	1st Assessment	2nd Assessment	3rd Assessment																					
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star																					
Date Assessed:	12/9/24																							
Assessor's signature:	Deborah Sullivan																							
Proposed Review date:	18/9/24																							

Continuation Sheet

[illegible]



	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen ☐ ☐ If yes, add details of oxygen therapy
Signature:	Signature:	
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation	Medium Clinical Risk Min Hourly Observations	High Clinical Risk Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response In Medical Notes	ACE Response In Medical Notes
		Think Sepsis If Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS	
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations	
Signed: _____	_____
Medical: _____	_____
Date: _____	_____

Glasgow Coma Scale

Pupil Reaction and size

0 = sluggish
 + = no reaction
 C = eyes closed

Pupil Size (mm)

1
2
3
4
5
6
7
8

Date: _____ Time: _____		11/17	11/18	11/19	11/20	11/21	11/22	11/23	11/24	11/25	11/26	11/27	11/28	11/29	11/30	12/1	12/2	12/3	12/4	12/5	12/6	12/7	12/8	12/9	12/10	12/11	12/12	12/13	12/14	12/15	12/16	12/17	12/18	12/19	12/20	12/21	12/22	12/23	12/24	12/25	12/26	12/27	12/28	12/29	12/30	1/1	1/2	1/3	1/4	1/5	1/6	1/7	1/8	1/9	1/10	1/11	1/12	1/13	1/14	1/15	1/16	1/17	1/18	1/19	1/20	1/21	1/22	1/23	1/24	1/25	1/26	1/27	1/28	1/29	1/30	2/1	2/2	2/3	2/4	2/5	2/6	2/7	2/8	2/9	2/10	2/11	2/12	2/13	2/14	2/15	2/16	2/17	2/18	2/19	2/20	2/21	2/22	2/23	2/24	2/25	2/26	2/27	2/28	2/29	2/30	3/1	3/2	3/3	3/4	3/5	3/6	3/7	3/8	3/9	3/10	3/11	3/12	3/13	3/14	3/15	3/16	3/17	3/18	3/19	3/20	3/21	3/22	3/23	3/24	3/25	3/26	3/27	3/28	3/29	3/30	3/31	4/1	4/2	4/3	4/4	4/5	4/6	4/7	4/8	4/9	4/10	4/11	4/12	4/13	4/14	4/15	4/16	4/17	4/18	4/19	4/20	4/21	4/22	4/23	4/24	4/25	4/26	4/27	4/28	4/29	4/30	4/31	5/1	5/2	5/3	5/4	5/5	5/6	5/7	5/8	5/9	5/10	5/11	5/12	5/13	5/14	5/15	5/16	5/17	5/18	5/19	5/20	5/21	5/22	5/23	5/24	5/25	5/26	5/27	5/28	5/29	5/30	5/31	6/1	6/2	6/3	6/4	6/5	6/6	6/7	6/8	6/9	6/10	6/11	6/12	6/13	6/14	6/15	6/16	6/17	6/18	6/19	6/20	6/21	6/22	6/23	6/24	6/25	6/26	6/27	6/28	6/29	6/30	6/31	7/1	7/2	7/3	7/4	7/5	7/6	7/7	7/8	7/9	7/10	7/11	7/12	7/13	7/14	7/15	7/16	7/17	7/18	7/19	7/20	7/21	7/22	7/23	7/24	7/25	7/26	7/27	7/28	7/29	7/30	7/31	8/1	8/2	8/3	8/4	8/5	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31	9/1	9/2	9/3	9/4	9/5	9/6	9/7	9/8	9/9	9/10	9/11	9/12	9/13	9/14	9/15	9/16	9/17	9/18	9/19	9/20	9/21	9/22	9/23	9/24	9/25	9/26	9/27	9/28	9/29	9/30	9/31	10/1	10/2	10/3	10/4	10/5	10/6	10/7	10/8	10/9	10/10	10/11	10/12	10/13	10/14	10/15	10/16	10/17	10/18	10/19	10/20	10/21	10/22	10/23	10/24	10/25	10/26	10/27	10/28	10/29	10/30	10/31	11/1	11/2	11/3	11/4	11/5	11/6	11/7	11/8	11/9	11/10	11/11	11/12	11/13	11/14	11/15	11/16	11/17	11/18	11/19	11/20	11/21	11/22	11/23	11/24	11/25	11/26	11/27	11/28	11/29	11/30	11/31	12/1	12/2	12/3	12/4	12/5
-------------------------	--	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	------	------	------	------

NEWS 2 Key 1 2 3

Date: 1/11/18
Time: 11:00

A + B
Respirations: 18
Breaths/min: 18

A + B
SpO2 Scale 1
Oxygen saturation (%): 98

SpO2 Scale 2
Oxygen saturation (%): 98

Air or oxygen? A A A A A A A A

C
Blood Pressure mmHg
Score uses systolic BP only

C
Pulse
Beats / min

D
Any changes to neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

E
Temperature

NEWS Total: 1 2 0 2 2 0 0 0

Blood glucose: 7.8
Pain / function score: 04
Time Pt last passed urine: 10:20
Fluid balance chart indicated Y/N: N
GCS indicated Y/N: N
Time NEWS due: 23:00
Escalation of care Y/N: N
Initials: AS

01/12/2018
SULLIVAN
Deborah
Flat 0-1, 8 Bopods Street
Eastbourne
East Sussex
G4 9JE

Abbreviations for recording oxygen device

A Room Air
N Nasal Cannulae
SM Simple Mask
V Venturi Mask and 9% eg. V24
NIV Non Invasive Ventilation
IV Invasive Ventilation
T Tracheostomy
CP CPAP Mask
HFN High Flow Nasal Oxygen
NEB Nebuliser
RM Reservoir Mask (Emergency use only)

Affix Patient ID

- NEWS > 4 THINK SEPSIS**
Apply SEPSIS 6 within 1 hour
1. Give oxygen to target saturation >94% (COPD >92%)
 2. IV fluids up to 20ml/kg
 3. Take blood cultures
 4. Measure lactate and FBC
 5. Give IV antibiotics
 6. Monitor urine output and fluid balance chart

- Think ACE**
- A Action:** Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
- C Communicate:** Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
- E Escalate:** Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.



5

Part 1
0712726128
SULLIVAN
Pat Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
Ficker

Emergency Care Nursing Documentation

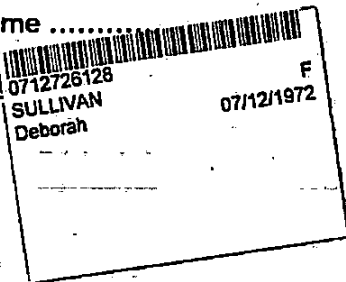
Initial Investigations				Communication					
Patient prepared for exam - clothing bagged				Y	N	GGC Red Bag with Patient (nursing home resident)		Y	N
NEWS Chart	Y	N	X-rays	Y	N	Language or hearing difficulty		Y	N
ID band	Y	N	Pain Score	Y	N	Interpreter required		Y	N
Peak Flow	Y	N	Please specify		what arrangements have been made?				
12-lead ECG	Y	N	Urinalysis	Y	N	Relatives / Carer / Next of Kin present		Y	N
IV access	Y	N	Positive findings		name, relationship, location, particular concerns				
Blood samples	Y	N							
Blood Gas	Y	N							
B-HCG				Y	N	Signature: _____			

Risk Assessments and Screening Tools					
SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Time: Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
4AT Assessment	Y	N	Frailty Assessment	Y	N
			Public Protection (NOC)	Y	N
Signature: _____					

Pause for Discharge or Transfer		
GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Risk Assessment/Screening Tools	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N
Signature: _____		

Patient name

Patient C



Care Rounds Checklist

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need, should be every (please circle) 1hr 2hr 3hr **4hr**

Signed Score Name Score Designation RM

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.	Y																				
	2	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If yes inform registered nurse.	Y																				
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU - Pressure Ulcer INT = Intact M = Moisture	Y																				
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand	Y																				
		ELIMINATION Does the patient need the toilet?	Y																				
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)	Y																				
N	6	FOOD FLUIDS AND NUTRITION Is the patient nil by mouth? Drink taken? Food, snack, or supplements taken? Has oral hygiene been carried out as per care plan?	Y																				
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?	Y																				
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return	Y																				
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return	Y																				
		Care provider	Y																				
		Role	Y																				

Ask the patient if there is anything they specifically want done today:

Pa 0712726128
SULLIVAN
Deborah
07/12/1972
F
sticker
sty MacDonald3

Hospital: *GNE*
Ward: *ATE*
Points to consider:
• Use within 8 hrs of admission to care area
• Re-assess daily and more frequently if a person's condition changes



PUDRA					
1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.			
Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		
2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?			
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?			
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?			
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?			
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:			

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____ hrly	
/ /	:							____ hrly	
/ /	:							____ hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/ carer YES / NO

Patient name

Patient CHI

or use sticker



Nursing notes cont.

Date and Time

Name/Signature

Patient name

Patient CHI

or use sticker



Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS, PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

Patient

Deborah

07/12/1972

F

Nursing notes

PECOS GGC0107

My Admission Record



0712725128
SULLIVAN
Deborah F
07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital: GRI Ward: 63
Date of Admission: 24.5.24 Time: 0645
Information obtained from: Name: Deborah
Patient ☒ Relative ☐ Other ☐
Preferred Name: Debbie
Age: 51 Telephone Number: 07713 718392
Consultant: Prof Jamieson

urine =

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☒
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☒
Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact

Name: Donna Sullivan
Relationship: Sister
Address: _____
Telephone: 07743956178
Is this person aware of your admission?
Yes ☐ No ☒
Can we share information with this person?
Yes ☒ No ☐

Preferred second contact

Name: _____
Relationship: _____
Address: _____
Telephone: _____
Is this person aware of your admission?
Yes ☐ No ☐
Can we share information with this person?
Yes ☐ No ☐

Presenting Complaint / Diagnosis

Epigastric pain
Explained to the patient? Yes ☐ No ☐ Not Applicable ☒
Do you understand the reason for your admission? Yes ☒ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ PENICILLIN (rash)

Relevant past medical history

T2DM. Fibromyalgia. Chronic pancreatitis. PD. HTN. GORD.
Cholecystectomy. Appendicectomy. Fundoplication. Constipation.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☒ If yes, Who asked for a copy? _____
Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

0712726128

SULLIVAN

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

This patient is not

Does someone have Power of Attorney (POA) for you?

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian _____

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47**Carbapenemase-producing enterobacteriaceae (CPE)**

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

☐☒

2. Received holiday dialysis outside Scotland?

☐☒

3. Been told that you have CPE?

☐☒

4. Been in close contact with a person with CPE?

☐☒If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

☐

Obtain Rectal swab marked 'for CPE'

☐

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

☐**and inform the IPCT**☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes

No

Unsure

☐☐☒If **YES** complete the following section

1. Have you ever been told that you have MRSA?

☐☒☐

2. Have you been admitted from another hospital/ residential setting or care home?

☐☒☐

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes

No

Unsure

☐☒☐If **YES** inform the IPCT ☐



0712726128

SULLIVAN

Deborah

07/12/1971

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Lifestyle**Smoking**Are you a: smoker ☐ ex-smoker ☒ when did you stop? 6 years ago.Never smoked ☐Do you use eCigarettes? Yes ☒ No ☐

If a smoker, the NHS GGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☒

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☒

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

DrugsDo you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHS GGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

AlcoholDo you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☒ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐**NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.**Name (Please PRINT): A-GOWIESignature: [Signature]Designation: SNDate: 24-5-24

My Assessment Record



0712726128
SULLIVAN
Deborah

F
07/12/1972

1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes	No	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?	✓	✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details:			

Name: _____
 A  _____
 0712726128 _____
 SULLIVAN F _____
 Deborah 07/12/1972 _____
 D: Flat 0-1, 8 Boyndie Street _____
 Easterhouse _____
 C: Glasgow, Lanarkshire G34 9JE _____
 Aff _____

3. Senses

Vision

Yes
✓

No
✓

Assessment of the patient's vision.

Do you have any problems with your vision?

Do you wear glasses?

Do you have your glasses with you?

Do you wear contact lenses?

Do you have your lenses with you?

Do you wear a prosthesis?

Distance ☐ Reading ☒ Both ☐

Hearing

Yes
✓

No
✓

Assessment of the patient's hearing

Do you have any problems with your hearing?

Do you have any hearing loss?

Do you use a hearing aid?

Do you have your hearing aid(s) with you?

Pain

Yes
✓

No
✓

Assessment of the patient's pain

Do you have pain?

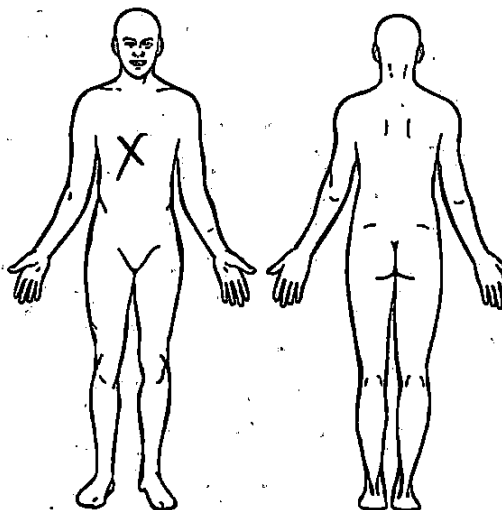
Can you describe where and what the pain is like?

'stabbing'

Mark current pain on body chart

Have you had treatment / intervention for the pain?

Analgesia



**N.B. Complete generic pain assessment chart.
 If unable to self report complete Abbey
 Pain Scale.**

Can you describe any chronic pain that you have?

Chronic pancreatitis/
 fibromyalgia.

What makes the pain better?

Regular analgesia



0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

patient ID label

4. Cognitive Status

THINK DELIRIUM

	Admission Presentation	Normal for the patient	Assessment of the patient's cognitive status
	✓	✓	
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

None

What do you like to eat and drink?

Varied

What do you not like to eat and drink?

Not fussy

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation	Normal for the patient	 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE NHS patient ID label
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			Assessment of the patient's hydration and nutrition needs
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	 0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE 07/12/1972 F label
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGCC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? *Yesterday*

How often in a day/week do you have a bowel movement? Per day Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☒ No ☐

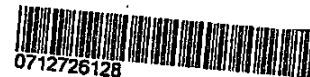
Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

Lactulose

N.B. If concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			



0712726128
SULLIVAN
Deborah

07/12/197

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation	Normal for the patient	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation	Normal for the patient	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes	No	Description of any dental work
Do you wear dentures?	✓	✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?		✓	
Skin Care	Admission Presentation	Normal for the patient	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name:  0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire 07/12/197 G34 9JL
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	Stick at home - only used occasionally
Unsteady when walking			
Do you use a mobility aid	Yes ☒ No ☐		
Do you have your mobility aid with you?	Yes ☐ No ☒		

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		Diazepam
Do you do or use anything to help you sleep?	✓		

N: 
 A: 0712726128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 07/12/197
 G34 9JL
 Affix patient

11. Social Circumstances

Do you:

Live alone

☒

Live with family/ friend/ other

☐

Live in a nursing home

☐

Live in a care home

☐

Live in residential supported care

☐

Live in student accommodation

☐

Live in 'homeless' accommodation

☐

Have no fixed abode

☐

Other please specify

☐

Dependants

Yes

☒

No

☒

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Cat

☒

Do they need support from someone else whilst you are in hospital?

☒

Would someone else be able to provide this support when you are in hospital?
 If yes, who?

Daughter

☒

If no support available contact Duty Social Worker

Duty Social Worker Required

☐

Not required

☒

Referred

☐

Services

Yes

☒

No

☒

Do you have support from social work, social services or a care package?

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

No

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

No

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed

Yes ☐

N/A ☒

N
A 0712726128
SULLIVAN
Deborah 07/12/197
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JL

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting better

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

Family

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....
.....

How do you want the people who matter to you to be involved in your care?

phone call

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐

N
A 0712726128
SULLIVAN
Deborah 07/12/197
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JL

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Self-employed ☐

Full time education ☐

Unemployed ☐

Retired ☒ - SICK

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☒

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____/____/____



0712726128

SULLIVAN

2 Deborah

07/12/197

Risk Assessments/Other Documentation

NHS patient ID label

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓		✓	
Generic Pain Scale Assessment Chart		✓		✓	
Abbey Pain Scale (if unable to self report pain)		✓		✓	
4AT and TIME for Detection, Management and Prevention of Delirium		✓		✓	
Getting to Know Me – Relatives to complete		✓		✓	
What Matters to Me		✓		✓	
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓		✓	
Malnutrition Universal Screening Tool (MUST)	✓		✓		24.5.24 A. GOWIE
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓		✓	
Bristol Stool Chart		✓		✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		24.5.24 A. GOWIE
Adult Wound Assessment and Management Chart		✓		✓	
Moving and Handling Assessment	✓		✓		24.5.24 A. GOWIE
Falls Risk Assessment	✓		✓		24.5.24 A. GOWIE
Bedrail Risk Assessment		✓		✓	

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
24.5.24	Patient admitted to ward 63	
0705	from A+E with Epigastric	
	pain. NEWS = (2) Bp 91/52. Independently	
	mobile, passing urine spontaneously.	
	Tolerating maximal diet + fluids	
	Sigs at present. Awaiting	A. GOWIE
	senior review	<i>[Signature]</i>

Clinical Notes (cont.)

16

0712726128

SULLIVAN

Deborah

07/12/1972

Flat 0-1, 8 Boydle Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Care Plan

NHS

Greater Glasgow
and Clyde

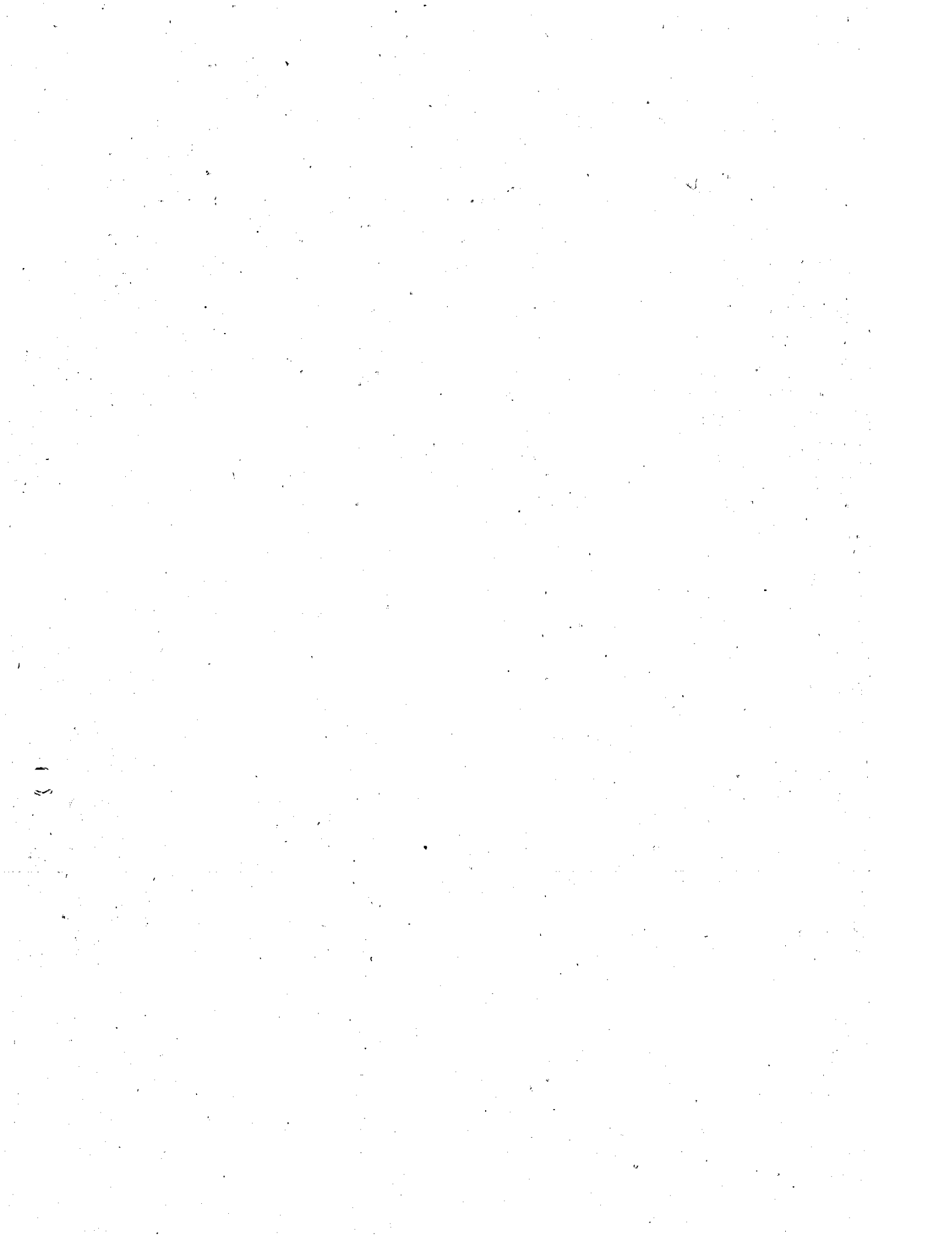
Care discussed with patient Unable		☒ Yes	☐ No	☐	If unable, give reason:	
Care discussed with family Unable		☐ Yes	☒ No	☐	If unable, give reason:	
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me <u>What Matters to Me</u>	Date discontinued & signature	
	Vital sign frequency as per News Score			Document daily "what matters to me" on care rounding		
24.5.24 AG	Measure & apply TED stockings unless contraindicated As per NEWS chart		24.5.24 AG	Getting better		
				5. Hydration and Nutrition		
				Sips water until medical review		
				Assess Nutritional needs - see MUST chart		
	2, 3. Communication and senses		24.5.24 AG	Sips at present		
	Give clear instructions / updates & check for understanding					
24.5.24 AG	Communicates well, Reading glasses in situ					
				6. Elimination		
	4. Cognitive status			Obtain Routine Specimen Urine/Ward testing; document results on MAR		
	Assess 4AT on admission			Observe for bowel function/ renal function		
24.5.24 AG	Alert + orientated		24.5.24 AG	Independent to toilet		

GRI 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1; 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Care Plan

NHS
Greater Glasgow
and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
	Assess ADL on admission & update careplan			Orientate to bed area / toilet facilities / buzzers	
	Daily PUORA			Care rounding - see chart for frequency	
24.5.24 AG	Independent with ADLs		24.5.24 AG	Call bell working + in reach	
				10. Sleep and Rest	
				Limit night time disruptions/ interventions	
				Observe comfort level via care rounding	
			24.5.24 AG	Promote peaceful environment	
	8. Mobility			12. Privacy, dignity and sexuality	
	Assess needs - see moving/handling careplan			Use curtains during intimate care	
	Complete bed rail risk assessment			Conduct discrete conversations	
24.5.24 AG	Complete full risk assessment on admission + following all pt transfers		24.5.24 AG	Maintain at all times	
	Independently when mobile, occasionally use stick due to fibromyalgia flare			Negotiated care - Please record any planned involvement of patient/family in delivery of care	
				Commence discharge plan on admission	



Per 0712728128 (nt) Moving and Handling Assessment Form

SULLIVAN.

Deborah

07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

Named Nurse:

A. GOLDIE

Person is totally Independent

(tick here and go to data box)



1. Gene

G34 9JE

ms with comprehension, behaviour, co-operation (specify):

Weight

Height

Kg

cm

BMI

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls:

Yes

No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 2 >3	Additional Information:		

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alend)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	24.5.24		
Assessor's signature:	A Goldie		
Proposed Review date:	31.5.24		

Continuation Sheet[illegible]

0712726126
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 63 Date: 21.5.24 Time: 07.00	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Complete				
2. Check walking aid (if required) is in reach and in use.	Independent				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Working in reach				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Safe				
5. If glasses are worn, check they are available and in use.	Reading				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

ALL patients in older people's wards must have an interventional plan in place (overleaf)

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			✓								
2. Does the patient have cognitive impairment or a possible delirium?			✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓								
5. Based on your clinical judgement, is this patient at high risk of falling?			✓								
Signature of nurse completing assessment / update:		Agdon									

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time:	Time:	Time:	Time:	Time:

BED AND SEATING				
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)				
Assess if a low bed is required (Patient care plan 9)				
SAFETY				
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.				
HEALTH				
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)				
Document continence problems and link to care rounding (Patient care plan 6)				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.				
COMMUNICATION				
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)				
Update the ward team of the patient's mobility status. (Patient care plan 8)				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)				
Signature of nurse completing interventional plan / or update				

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pressure Ulcer Daily Risk Assessment (PUDRA)

 0712726128 SULLIVAN Deborah Flat 0-1; 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: CR1	Points to consider:
	Ward: Ward 10	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf...
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
24/5/24	07:00	N	N	N	N	N	N	4 hrly	<i>[Signature]</i>
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan



Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.



0712726128
SULLIVAN
Deborah
F
07/12/1972

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly. • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly. • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly. • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

Date: 24.5.24

1. Signed A. Goldie Name A. GOLDIE Designation JN
2. Signed Barney Name Barney Designation SN
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

G34 9JE

NHS
Greater Glasgow
and Clyde

[illegible]

Attach Adc

0712726128
SULLIVAN
Deborah

F
07/12/1972

Ward:



1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

[illegible]

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

0712726128

SULLIVAN
Deborah

Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

CHI:

Address:

Hospital:



Insertion criteria

Intravascular devices are associated with arterial thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) - Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC inserted: Day 0

Date: ___/___/___

Hospital: _____

Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____

Insertion site:

R Hand ☐

R Arm ☐

R Foot ☐

L Hand ☐

L Arm ☐

L Foot ☐

Other: _____

Colour of cannula:

Blue ☐

Pink ☐

Green ☐

White ☐

Grey ☐

Orange ☐

Explanation and PVC
leaflet provided to
patient/ carer

Yes ☐ No ☐

If No, state reason: _____

PVC Maintenance
Check

Does the Patient require this
PVC for any of the DRIFT
criteria?

Diagnostics
Resuscitation/ Chest Pain
IV Drugs
Fluids
Transfusion

VIP score. (See
Chart on back of
care plan)

If ≥ 2 remove
PVC and record
reason*.

Is the PVC
dressing
intact?

If PVC used for
IV antibiotics
can these be
switched to oral?
(See IVOST
Flowchart on back
of care plan)

Initial

Day 1 Check 1

Day

___/___/___

Yes ☐ No ☐

If No, remove PVC and record
date and reason*.

VIP: _____

Yes ☐ No ☐

Yes ☐ No ☐
N/A ☐

Day 1 Check 2

Night

___/___/___

Yes ☐ No ☐

If No, remove PVC and record
date and reason*.

VIP: _____

Yes ☐ No ☐

Yes ☐ No ☐
N/A ☐

Day 2 Check 1

Day

___/___/___

Yes ☐ No ☐

If No, remove PVC and record
date and reason*.

VIP: _____

Yes ☐ No ☐

Yes ☐ No ☐
N/A ☐

Day 2 Check 2

Night

___/___/___

Yes ☐ No ☐

If No, remove PVC and record
date and reason*.

VIP: _____

Yes ☐ No ☐

Yes ☐ No ☐
N/A ☐

Day 3 Check 1

Day

___/___/___

Yes ☐ No ☐

If No, remove PVC and record
date and reason*.

VIP: _____

Yes ☐ No ☐

Yes ☐ No ☐
N/A ☐

Day 3 Check 2

Night

___/___/___

Yes ☐ No ☐

If No, remove PVC and record
date and reason*.

VIP: _____

Yes ☐ No ☐

Yes ☐ No ☐
N/A ☐

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P. (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis: Observe cannula
One of the following is evident: slight pain or redness near site	1	Possible first signs: Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis: Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

0712726128
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

	Date	Ward	Time
Admitted	24.5.24	Ward 63	0700
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1
Target >96%

Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

SpO2 Scale 2
Target 88-92%

Signature: _____
Print Name: _____
Dr/ANP Initials ONLY: _____
Date: _____

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response In Medical Notes Think Sepsis If Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response In Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed: _____
Medical: _____
Date: _____

Glasgow Coma Scale

Pupil Reaction and Size
1 = sluggish
+ = no reaction
C = eyes closed

Pupil Size (mm)
1 2 3 4 5 6 7 8

Eye	Open	Spontaneous	To speech	To pain	Score
Right					
Left					
TOTAL					

Always record the best response

Right size: P 4
Right reaction: P 4
Left size: L 4
Left reaction: L 4

Record right (R) and left (L) responses separately if there is a difference between the two sides

Record right (R) and left (L) responses separately if there is a difference between the two sides

Affix Patient ID

Pain Function Score

A No limitations, activity unrestricted by pain or settles quickly
B Mild limitations, mild activity restrictions
C Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Pain Score

Ask the patient to rate their pain by using numerical scale 0 to 10. Use the chart below to assist the patient if the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain	Moderate Pain	Severe Pain
0	1	2	3
4	5	6	7
8	9	10	

NI 316454 v5.1 • GCG0264

NEWS 2 Key 1 2 3

Date 1/11
Time 11:00

A + B
Respirations
Breaths/min

A + B
SpO2 Scale 1
Oxygen saturation (%)

SpO2 Scale 2
Oxygen saturation (%)
Use SpO2 at Arterial / finger
10-92-94% normal
hypoxia respiratory failure

Air or oxygen?

C
Blood Pressure mmHg
(Score uses systolic BP only)

C
Pulse
Beats / min

D
Any changes in neuro
response, do GCS.
Assess/Reassess mental status.
Check Elevated Glucose.
Think Delirium.

E
Temperature

NEWS Total

Blood glucose
Pain / function score
Time Pt last passed urine
Fluid balance chart
indicated Y/N
GCS indicated Y/N
Time NEWS due
Escalation of care Y/N
Initials

07/12/2018
SULLIVAN
Dobson
Flat 0-1, 8 Boydrie Street
Eastbourne
Glasgow, Lanarkshire
G34 8JE

Abbreviations for
recording oxygen
device

A Room Air
N Nasal
Cannulae
SM Simple Mask
V Venturi Mask
and %
eg. V24
NIV Non Invasive
Ventilation
IV Invasive
Ventilation
T Tracheostomy
CP CPAP Mask
HFN High Flow
Nasal Oxygen
NEB Nebuliser
RM Reservoir
Mask
(Emergency
use only)

07/12/2018
SULLIVAN
Dobson
Flat 0-1, 8 Boydrie Street
Eastbourne
Glasgow, Lanarkshire
G34 8JE

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

My Admission Record



Hospital: CR1 Ward: 62
 Date of Admission: 16/1/24 Time: 02:00
 Information obtained from: Name: _____
 Patient ☒ Relative ☐ Other ☐
Preferred Name: _____
 Age: 51 Telephone Number: 07713718392
 Consultant: _____

Nan: _____
 Add: _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 DoB: Flat 0-1, 8 Boyndie Street
 Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix: _____ G34 9JE

Communication
 What is your first language? English
 Do you require an interpreter? Yes ☐ No ☒
 If yes, provide details of arrangements made _____
 Do you use British Sign Language (BSL)? Yes ☐ No ☒
 Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact	Preferred second contact
Name: <u>Deanna Sullivan</u>	Name: <u>Courtney Kelly</u>
Relationship: <u>Sister</u>	Relationship: <u>Daughter</u>
Address: _____	Address: _____
Telephone: <u>07743956178</u>	Telephone: <u>07487257039</u>
Is this person aware of your admission? Yes ☒ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☒ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis
back pain
 Explained to the patient? Yes ☒ No ☐ Not Applicable ☐
 Do you understand the reason for your admission? Yes ☒ No ☐
Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)
 No known allergies ☐ penicillin - rash
Relevant past medical history
T2DM - med controlled
fibromyalgia
chronic pancreatitis 2nd to gallstones
 On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
 Yes ☐ No ☒ If yes, Who asked for a copy? _____
 Date they asked for a copy /// Date Obtained ///

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Name

Add

0712728128

SULLIVAN

Deborah

07/12/1972

DoB

CHI:

Affix patient ID label

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

Yes

No

2. Received holiday dialysis outside Scotland?

3. Been told that you have CPE?

4. Been in close contact with a person with CPE?

If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'
and inform the IPCT**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

If **YES** complete the following section

1. Have you ever been told that you have MRSA?

2. Have you been admitted from another hospital/ residential setting or care home?

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes

No

Unsure

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care -- obtain MRSA swabsNasal ☒ Perineum ☒ Other ☒ Specify throat Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

If **YES** inform the IPCT ☐

Yes

No

Unsure

Nar  _____
 Adc 0712726128 _____
 SULLIVAN _____
 Deborah _____ F _____
 07/12/1972 _____
 Do _____
 CP _____
 Affix patient ID label _____

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☒ when did you stop? 6 years ago

Never smoked ☐

Do you use eCigarettes? Yes ☒ No ☐

If a smoker, the NHSGCC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☒

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☒

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGCC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals.

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): Suzanne O'Keeffe Signature: [Signature]

Designation: SN Date: 16/1/24

My Assessment Record

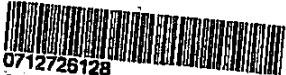
Name: _____
 Address: _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boydle Street
 DoB: Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix patient ID label G34 9JE

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?			
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team?			
Contact details:			

Name:  —
 Address: 0712726128 —
 SULLIVAN —
 Deborah — F —
 Flat 0-1, 8 Boyndie Street —
 Easterhouse —
 Glasgow, Lanarkshire —
 DoB: —
 CHI: —
 Affix patient ID label: G34 8JE

3. Senses			
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?		✓	
Do you wear a prosthesis?		✓	
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

numbness, pins + needles

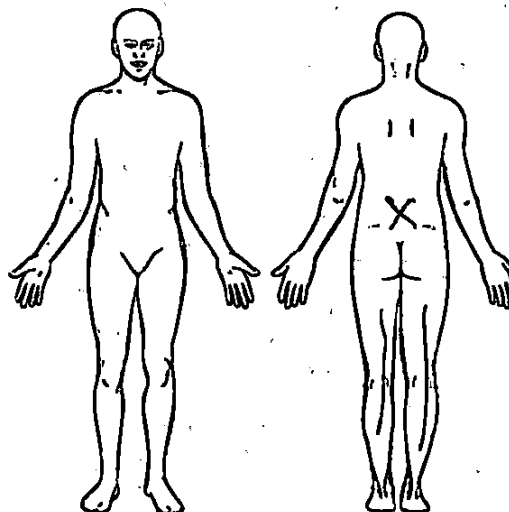
Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



N
A: 
0712728128
— SULLIVAN F
— Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
D: Easterhouse
C: Glasgow, Lanarkshire G34 9JE
After patient ID (AUCI)

4. Cognitive Status		THINK DELIRIUM		Assessment of the patient's cognitive status
	Admission Presentation	Normal for the patient		
Alert and orientated	✓	✓		
Impaired conscious level				
Confused				
Dementia				
Stressed / Distressed				

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

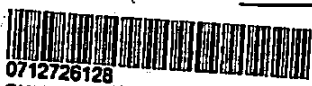
nm

What do you like to eat and drink?

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	Nar Adc 0712726128 SULLIVAN Deborah 07/12/1972 F Do CH Affix patient ID label
Normal diet and fluids		✓	Assessment of the patient's hydration and nutrition needs
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)		✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems		✓	New Incontinence tablets due to back pain / numbness
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name _____ Ad  0712726128 SULLIVAN Deborah F 07/12/1972 D: Flat 0-1, 8 Boyndie Street Cl Easterhouse Glasgow, Lanarkshire Al G34 8JE
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGCC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? 15/11/23

How often in a day/week do you have a bowel movement? Per day Per week

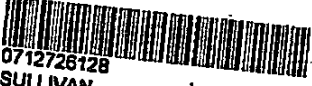
Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?			
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

Nam  _____
 Add: 0712728128 _____
 SULLIVAN _____
 Deborah _____
 Flat 0-1, 8 Boyndie Street 07/12/1972 F _____
 Easterhouse _____
 DoI Glasgow, Lanarkshire _____
 CH _____
 Affix patient ID label G34 9JE

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent		✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems		✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems		✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name:  Address: 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boydrie Street DoB: Easterhouse CHI: Glasgow, Lanarkshire Affix patient ID label G34 8JE
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent		✓	X1 etc.
Unsteady when walking			
Do you use a mobility aid	Yes ☒	No ☐	
Do you have your mobility aid with you?	Yes ☒	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

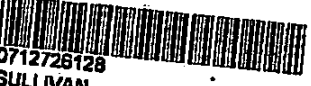
N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

Name: _____
 Address: 
 0712726128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 DoB: _____ 07/12/1972
 CHI: _____
 Affix p: _____
 G34 8JE

11. Social Circumstances

Do you:

Live alone ☒

Live with family/ friend/ other ☐

Live in a nursing home ☐

Live in a care home ☐

Live in residential supported care ☐

Live in student accommodation ☐

Live in 'homeless' accommodation ☐

Have no fixed abode ☐

Other please specify _____ ☐

Dependants

Yes

No

Do you have any dependants? ☒

Do you support anyone (e.g. partner, children, relatives, cat)? ☒

Do they need support from someone else whilst you are in hospital? ☒

Would someone else be able to provide this support when you are in hospital? ☒

If yes, who? Daughter

If no support available contact Duty Social Worker

Duty Social Worker Required ☐

Not required ☒

Referred ☐

Services

Yes

No

Do you have support from social work, social services or a care package? ☒

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission? ☐

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed

Yes ☐

N/A ☒

Name: 
 Address: 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boydrie Street
 DoB: Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix patient ID number G34 8JE

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☒

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
 (please tick) Yes ☐ No ☒

Name  _____
 Address 0712726128 _____
 SULLIVAN _____ F _____
 Deborah 07/12/1972 _____
 Flat 0-1, 8 Boyndie Street _____
 DoB Easterhouse _____
 CHI: Glasgow, Lanarkshire _____
 Affix G34 9JE _____

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☒

Self-employed ☐

Retired ☐

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☒

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☒

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

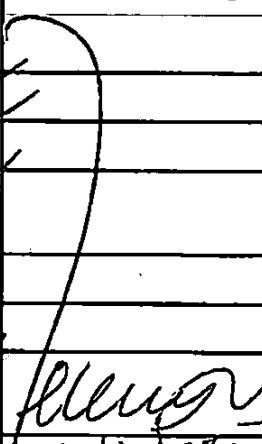
Yes ☐ No ☐ Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____/____/____

N-----
A  _____
0712726128
- SULLIVAN F_____
- Deborah 07/12/1972 _____
D Flat D-1, 8 Boyndie Street _____
C Easterhouse _____
Glasgow, Lanarkshire _____
Al G34 9JE _____

Risk Assessments/Other Documentation

Additional NHSGCC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓	✓	✓	 16/11/24
Generic Pain Scale Assessment Chart		✓	✓	✓	
Abbey Pain Scale (if unable to self report pain)		✓	✓	✓	
4AT and TIME for Detection, Management and Prevention of Delirium		✓	✓	✓	
Getting to Know Me – Relatives to complete		✓	✓	✓	
What Matters to Me		✓	✓	✓	
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓	✓	✓	
Malnutrition Universal Screening Tool (MUST)	✓		✓	✓	
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓	✓	✓	
Bristol Stool Chart		✓	✓	✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓	✓	
Adult Wound Assessment and Management Chart		✓	✓	✓	
Moving and Handling Assessment		✓	✓	✓	
Falls Risk Assessment	✓		✓	✓	
Bedrail Risk Assessment		✓	✓	✓	

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
	Pt admitted to W062 With back pain + numbness. Mobilising with X1 E/C independently - MESA snabs obtained - NRS = 1 on admission for slight tachy. Pt stated	

Name: _____
 Address: 0712726128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boydrie Street
 Easterhouse
 Glasgow, Lanarkshire
 Date of birth: 07/12/1972
 Gender: F
 GP: G34 8JE
 Affix patient ID label

Clinical Notes (cont.)

[illegible]

Na _____
Ad _____
0712728128
— SULLIVAN F
— Deborah — 07/12/1972

[illegible]

Discharge Checklist

Patient's name:		Ward: 62		
CHI number	0712728128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Discharge destination: home		
07/12/1972 F		Estimated Discharge Date (1) 7 / 1		
		Estimated Discharge Date (2) 1 / 1		
		Final date of discharge: 17 / 1 / 24		
Checklist	Yes	N/A	Initials	Comments
Patient informed	☒		dl	
Relative/carer informed				
Relative/carer involved in discharge planning discussions				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	☒		dl	
Ambulance: 1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Immediate Discharge Letter completed	☒		dl	
Compliance aids e.g. Dosette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies				
Homecare				
Homecare request form completed?				
Discharge lounge handover completed?				
Physiotherapist				
Occupational Therapist				
Dietitian				
Speech and Language Therapist				
Clinical Nurse specialist				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Outpatient clinic appointment				
Arranged			NFLU	
To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature: 	Designation:	Date: / /		



C WARD CHART (NON INSULIN)

0712726128

SULLIVAN

Deborah

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

F

07/12/1972

WARD: 62

CONSULTANT:

NAME:

UNIT No.:

G34 9JE

DATE	16/01/24																							
TIME	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.
% GLYCOSURIA	2																							
	1																							
	3/4																							
	1/2																							
	1/4																							
0																								
KETONES																								
BLOOD GLUCOSE																								

DATE																								
TIME	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.
% GLYCOSURIA	2																							
	1																							
	3/4																							
	1/2																							
	1/4																							
0																								
KETONES																								
BLOOD GLUCOSE																								

DATE																								
TIME	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.	7 a.m.	11.30 a.m.	5 p.m.	9 p.m.
% GLYCOSURIA	2																							
	1																							
	3/4																							
	1/2																							
	1/4																							
0																								
KETONES																								
BLOOD GLUCOSE																								

Pers 0712726128 SULLIVAN Deborah 07/12/1972 (nt) Moving and Handling Assessment Form

Person's Name:	Deborah Flat 0-1, 8 Boydrie Street Easterhouse Glasgow, Lanarkshire	aged urse:	Person is totally Independent (tick here and go to data box)
----------------	--	---------------	---

1. General information G34 9JE

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	
BMI		
Risk of Falls: Yes ☐ No ☐		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

2. Sit to Stand to Sit Transfers (including to and from bed, wheelchair, commode and toilet)

Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Slung type					
Slung Size					

3. Toileting

Hoist	Standard	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		People: 1 2 >3	Additional Information:		

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Independent bridging	People: 1 2 >3	Additional Information:	

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1 2 >3	Additional Information:	

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):	

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alaris)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
see 'sit to stand transfers'		People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	16/1/24		
Assessor's signature:	<i>Deborah</i>		
Proposed Review date:	18/2		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)									
Body Build			Problems with comprehension, behaviour, co-operation (specify):						
Weight		Height							
Kg		cm							
BMI									
Risk of Falls: Yes ☐ No ☐			Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):						
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
Model:		Aid Type	People: 1	2	>3	Additional Information / Equipment:			
Sling type									
Sling Size									
3. Toileting									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'		People: 1	2	>3	Additional Information:			
4. Move on / off bed pan									
Hoist	Manoeuvre	Assistance			Supervision		N/A		
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1	2	>3	Additional Information:				
	Monkey pole								
	Person bridges								
5. Move up / down bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1	2	>3	Additional Information:				
	Monkey pole								
	Rope ladder								
6. Lateral Transfer to / from trolley / bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):				
	Other (Please specify)								
7. Sit up over side of bed									
	Bed Rest	Assistance			Supervision		Independent		
		People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):				
8. Into Bath or Shower									
Equipment	Handling Aid	Assistance			Supervision		Independent		
Shower	Shower chair	People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):				
Variable / Fixed height bath	Shower trolley								
Bed bath	Bathing hoist (eg Altec)								
9. Walking									
No Walking	Walking Aid	Assistance			Supervision		Independent		
	see 'sit to stand transfers'	People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. walked)				
10. Other Instructions / Observations / Equipment Used									
		4 th Assessment		5 th Assessment		6 th Assessment			
Recording Symbol:		/ Forward slash		X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists add slashes to make a star			
Date Assessed:									
Assessor's signature:									
Proposed Review date:									

Pressure Ulcer Daily Risk Assessment (PUDRA)

 0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: 921 Ward: 62	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	---	--

1 Pressure Damage N	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
16/12/17	0:30	N	N	Y	N	N	N	4hrly	[Signature]
17/12/17	0:00	N	N	Y	N	N	N	4hrly	[Signature]
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.



Outcome: To prevent pressure ulcer development through establishment of effective working practices in line with SSKINS bundle.



0712728128
SULLIVAN
Deborah 07/12/1872
Flat 0-1, 8 Boydla Street
Easterhouse
Glasgow, Lanarkshire.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	SELF MANAGEMENT / SHARED CARE	GP SIGNATURE
Date of plan: 16/1	Check: - Pressure areas <u>4</u> hourly. - Skin under medical devices <u>4</u> hourly. - Specify medical devices used:	Specify: - Mattress: <u>heatzave</u> - Cushion: - Detail additional pressure redistributing equipment:	- Reposition <u>4</u> hourly in bed and chair. - Overnight patient / carer has agreed to repositioning <u> </u> hourly - Specify any manual handling equipment used:	- Skin care to be carried out <u>4</u> hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree plan with patient / family / carer YES ☒ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☒ NO ☐	<i>Deborah Sullivan</i> Date discontinued: _____
Date Reviewed:	Check: - Pressure areas <u> </u> hourly. - Skin under medical devices <u> </u> hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition <u> </u> hourly in bed and chair. - Overnight patient / carer has agreed to repositioning <u> </u> hourly - Specify any manual handling equipment used:	- Skin care to be carried out <u> </u> hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: - Pressure areas <u> </u> hourly. - Skin under medical devices <u> </u> hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition <u> </u> hourly in bed and chair. - Overnight patient / carer has agreed to repositioning <u> </u> hourly - Specify any manual handling equipment used:	- Skin care to be carried out <u> </u> hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family / carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)



Date _____ Time _____ of initial height and weight on admission to hospital	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>176</u> cm	☐	☐	
Admission Weight <u>94.5</u> Kg	☐	☐	

* Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	<u>16/1</u>						
Time	<u>15:50</u>						
Ward	<u>62</u>						
Oedema/ Ascities present Y/N	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>CH</u>						
Weight (kgs)	<u>94.5</u>						
BMI	<u>30</u>						

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on	<u>23/1</u>						
Signature	<u>CW</u>						

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ⓪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- Use a Food First Approach:
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patients intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

Complete the above steps

Is the patient dying?

YES

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Traskare.

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

0712728128
SULLIVAN
Deborah
Flat 0-1, 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 8JE

Care Plan



Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
16/11/24 SC	Independent with personal care		16/11/24 SC	Buzzer in reach	
				10. Sleep and Rest	
			16/11/24 SC	promote - no issues at home	
	8. Mobility				
16/11/24 SC	Independent x1 E/C			12. Privacy, dignity and sexuality	
			16/11/24 SC	upheld at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	
				Anticipatory med + neuro advice	

0712728128
SULLIVAN
Deborah Patient Label 07/12/1872 F

Care Plan

Care discussed with patient		☒ Yes	☐ No	☐	If unable, give reason:	
Unable						
Care discussed with family		☒ Yes	☐ No	☐	If unable, give reason:	
Unable						
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature	
16/1/24 SC	SENO issues		16/1/24 SC	Getting better		
				5. Hydration and Nutrition		
			16/1/24 SC	Normal		
	2, 3. Communication and senses					
16/1/24 SC	wears reading glasses					
				6. Elimination		
	4. Cognitive status		16/1/24 SC	new incontinence today		
16/1/24 SC	DEA + orientated			due to injury		
				BO @ home 15/1/24		

0712728128
SULLIVAN F
Deborah 07/12/1972
Flat Q-1, 8 Boydrie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 6Z Date: 16/11/24 Time: 02:30	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----	Ward: Date: Time: -----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Ind x1 EIC				
2. Check walking aid (if required) is in reach and in use.	In reach				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Working + available				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Safe				
5. If glasses are worn, check they are available and in use.	Available				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			/								
2. Does the patient have cognitive impairment or a possible delirium?			/								
3. Does the patient attempt to walk alone although unsteady or unsafe?			/								
4. Does the patient or their relative have a fear or anxiety of the patient falling?			/								
5. Based on your clinical judgement, is this patient at high risk of falling?			/								
Signature of nurse completing assessment / update											

Highlight risk of fall at the ward safety brief.

0712728128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boydell Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

FALLS INTERVENTION CHECKLIST

NHS
Greater Glasgow
and Clyde

Complete for all patients identified at risk of falling.

Ward: G2	Ward:	Ward:	Ward:	Ward:
Date: 16/1/24	Date:	Date:	Date:	Date:
Time: 02:35	Time:	Time:	Time:	Time:

BED AND SEATING				
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	not required			
Assess if a low bed is required (Patient care plan 9)	Not required			
SAFETY				
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	not in use			
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	not a fall risk			
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	Alert + orientated			
HEALTH				
Complete / Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	N/A			
Document continence problems and link to care rounding (Patient care plan 6)	new incontinence			
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	not required			
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	ongoing			
COMMUNICATION				
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	discussed			
Update the ward team of the patient's mobility status. (Patient care plan 8)	ongoing			
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	ongoing			
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	not required			
Signature of nurse completing Interventional plan / or update	Deborah Sullivan 17/1/24			

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Feb 17 MI • 294647c Version 1.0 • GGC0233

NHSGCC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name

CHI Number

0712728128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
07/12/1972
F
G34 9JE



Use guidance on the reverse of this document when completing this Risk Assessment		DATE	16/11/24								
		TIME	02:35								
		WARD	02								
		HOSPITAL	Q21								
SECTION ONE - GENERAL				Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?		/								
2	Has the patient requested the use of bedrails?		/								
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED											
SECTION TWO - COGNITIVE AND PHYSICAL STATUS											
3	Is the patient at risk of climbing out of bed?		/								
4	Is the patient stressed, delirious or restless?		/								
5	Is the patient small in stature?		/								
6	Does the patient have an unusually large or small head that might present an entrapment issue?		/								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		/								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf											
SECTION THREE - COMMUNICATION											
8	Has the patient been consulted regarding the use of bedrails?		/								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		/								
10	Has the use of bedrails been discussed with relatives/carers?		/								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		/								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		/								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf											
SECTION FOUR - DECISION MAKING											
13	Will bedrails be used for this patient at the present time?		/								
14	Rationale for use of bedrails: (Please insert code in the box on the right)										
	A - Risk of falling from the bed										
	B - Risk of rolling from the bed										
	C - Risk of slipping from the bed										
	D - Risk of sliding from the bed										
	E - Patient request										
15	Bedrail risk assessment completed by:		Downs								
16	Bedrails checked by:		Downs								
17	Date		16/11/24								
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here											

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

**B. If bedrails are to be used, please consider the following:-
Is patient:-**

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and/or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

[illegible]

Date: 16/1/24

1. Signed [Signature] Name Gunnar Gustaf Designation EN
2. Signed _____ Name _____ Designation _____
3. Signed [Signature] Name Gunnar Gustaf Designation EN

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

NHS
Greater Glasgow
and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

		Times	07-06-20	08-06-20	09-06-20	10-06-20	11-06-20	12-06-20	13-06-20	14-06-20	15-06-20	16-06-20	17-06-20	18-06-20	19-06-20	20-06-20	21-06-20	22-06-20	23-06-20	24-06-20	25-06-20	26-06-20	27-06-20	28-06-20	29-06-20	30-06-20	01-07-20	02-07-20	03-07-20	04-07-20	05-07-20	06-07-20	07-07-20	08-07-20	09-07-20	10-07-20	11-07-20	12-07-20	13-07-20	14-07-20	15-07-20	16-07-20	17-07-20	18-07-20	19-07-20	20-07-20	21-07-20	22-07-20	23-07-20	24-07-20	25-07-20	26-07-20	27-07-20	28-07-20	29-07-20	30-07-20	31-07-20	01-08-20	02-08-20	03-08-20	04-08-20	05-08-20	06-08-20	07-08-20	08-08-20	09-08-20	10-08-20	11-08-20	12-08-20	13-08-20	14-08-20	15-08-20	16-08-20	17-08-20	18-08-20	19-08-20	20-08-20	21-08-20	22-08-20	23-08-20	24-08-20	25-08-20	26-08-20	27-08-20	28-08-20	29-08-20	30-08-20	31-08-20	01-09-20	02-09-20	03-09-20	04-09-20	05-09-20	06-09-20	07-09-20	08-09-20	09-09-20	10-09-20	11-09-20	12-09-20	13-09-20	14-09-20	15-09-20	16-09-20	17-09-20	18-09-20	19-09-20	20-09-20	21-09-20	22-09-20	23-09-20	24-09-20	25-09-20	26-09-20	27-09-20	28-09-20	29-09-20	30-09-20	01-10-20	02-10-20	03-10-20	04-10-20	05-10-20	06-10-20	07-10-20	08-10-20	09-10-20	10-10-20	11-10-20	12-10-20	13-10-20	14-10-20	15-10-20	16-10-20	17-10-20	18-10-20	19-10-20	20-10-20	21-10-20	22-10-20	23-10-20	24-10-20	25-10-20	26-10-20	27-10-20	28-10-20	29-10-20	30-10-20	31-10-20	01-11-20	02-11-20	03-11-20	04-11-20	05-11-20	06-11-20	07-11-20	08-11-20	09-11-20	10-11-20	11-11-20	12-11-20	13-11-20	14-11-20	15-11-20	16-11-20	17-11-20	18-11-20	19-11-20	20-11-20	21-11-20	22-11-20	23-11-20	24-11-20	25-11-20	26-11-20	27-11-20	28-11-20	29-11-20	30-11-20	01-12-20	02-12-20	03-12-20	04-12-20	05-12-20	06-12-20	07-12-20	08-12-20	09-12-20	10-12-20	11-12-20	12-12-20	13-12-20	14-12-20	15-12-20	16-12-20	17-12-20	18-12-20	19-12-20	20-12-20	21-12-20	22-12-20	23-12-20	24-12-20	25-12-20	26-12-20	27-12-20	28-12-20	29-12-20	30-12-20	31-12-20	01-01-21	02-01-21	03-01-21	04-01-21	05-01-21	06-01-21	07-01-21	08-01-21	09-01-21	10-01-21	11-01-21	12-01-21	13-01-21	14-01-21	15-01-21	16-01-21	17-01-21	18-01-21	19-01-21	20-01-21	21-01-21	22-01-21	23-01-21	24-01-21	25-01-21	26-01-21	27-01-21	28-01-21	29-01-21	30-01-21	31-01-21	01-02-21	02-02-21	03-02-21	04-02-21	05-02-21	06-02-21	07-02-21	08-02-21	09-02-21	10-02-21	11-02-21	12-02-21	13-02-21	14-02-21	15-02-21	16-02-21	17-02-21	18-02-21	19-02-21	20-02-21	21-02-21	22-02-21	23-02-21	24-02-21	25-02-21	26-02-21	27-02-21	28-02-21	29-02-21	01-03-21	02-03-21	03-03-21	04-03-21	05-03-21	06-03-21	07-03-21	08-03-21	09-03-21	10-03-21	11-03-21	12-03-21	13-03-21	14-03-21	15-03-21	16-03-21	17-03-21	18-03-21	19-03-21	20-03-21	21-03-21	22-03-21	23-03-21	24-03-21	25-03-21	26-03-21	27-03-21	28-03-21	29-03-21	30-03-21	31-03-21	01-04-21	02-04-21	03-04-21	04-04-21	05-04-21	06-04-21	07-04-21	08-04-21	09-04-21	10-04-21	11-04-21	12-04-21	13-04-21	14-04-21	15-04-21	16-04-21	17-04-21	18-04-21	19-04-21	20-04-21	21-04-21	22-04-21	23-04-21	24-04-21	25-04-21	26-04-21	27-04-21	28-04-21	29-04-21	30-04-21	01-05-21	02-05-21	03-05-21	04-05-21	05-05-21	06-05-21	07-05-21	08-05-21	09-05-21	10-05-21	11-05-21	12-05-21	13-05-21	14-05-21	15-05-21	16-05-21	17-05-21	18-05-21	19-05-21	20-05-21	21-05-21	22-05-21	23-05-21	24-05-21	25-05-21	26-05-21	27-05-21	28-05-21	29-05-21	30-05-21	31-05-21	01-06-21	02-06-21	03-06-21	04-06-21	05-06-21	06-06-21	07-06-21	08-06-21	09-06-21	10-06-21	11-06-21	12-06-21	13-06-21	14-06-21	15-06-21	16-06-21	17-06-21	18-06-21	19-06-21	20-06-21	21-06-21	22-06-21	23-06-21	24-06-21	25-06-21	26-06-21	27-06-21	28-06-21	29-06-21	30-06-21	01-07-21	02-07-21	03-07-21	04-07-21	05-07-21	06-07-21	07-07-21	08-07-21	09-07-21	10-07-21	11-07-21	12-07-21	13-07-21	14-07-21	15-07-21	16-07-21	17-07-21	18-07-21	19-07-21	20-07-21	21-07-21	22-07-21	23-07-21	24-07-21	25-07-21	26-07-21	27-07-21	28-07-21	29-07-21	30-07-21	31-07-21	01-08-21	02-08-21	03-08-21	04-08-21	05-08-21	06-08-21	07-08-21	08-08-21	09-08-21	10-08-21	11-08-21	12-08-21	13-08-21	14-08-21	15-08-21	16-08-21	17-08-21	18-08-21	19-08-21	20-08-21	21-08-21	22-08-21	23-08-21	24-08-21	25-08-21	26-08-21	27-08-21	28-08-21	29-08-21	30-08-21	31-08-21	01-09-21	02-09-21	03-09-21	04-09-21	05-09-21	06-09-21	07-09-21	08-09-21	09-09-21	10-09-21	11-09-21	12-09-21	13-09-21	14-09-21	15-09-21	16-09-21	17-09-21	18-09-21	19-09-21	20-09-21	21-09-21	22-09-21	23-09-21	24-09-21	25-09-21	26-09-21	27-09-21	28-09-21	29-09-21	30-09-21	01-10-21	02-10-21	03-10-21	04-10-21	05-10-21	06-10-21	07-10-21	08-10-21	09-10-21	10-10-21	11-10-21	12-10-21	13-10-21	14-10-21	15-10-21	16-10-21	17-10-21	18-10-21	19-10-21	20-10-21	21-10-21	22-10-21	23-10-21	24-10-21	25-10-21	26-10-21	27-10-21	28-10-21	29-10-21	30-10-21	31-10-21	01-11-21	02-11-21	03-11-21	04-11-21	05-11-21	06-11-21	07-11-21	08-11-21	09-11-21	10-11-21	11-11-21	12-11-21	13-11-21	14-11-21	15-11-21	16-11-21	17-11-21	18-11-21	19-11-21	20-11-21	21-11-21	22-11-21	23-11-21	24-11-21	25-11-21	26-11-21	27-11-21	28-11-21	29-11-21	30-11-21	01-12-21	02-12-21	03-12-21	04-12-21	05-12-21	06-12-21	07-12-21	08-12-21	09-12-21	10-12-21	11-12-21	12-12-21	13-12-21	14-12-21	15-12-21	16-12-21	17-12-21	18-12-21	19-12-21	20-12-21	21-12-21	22-12-21	23-12-21	24-12-21	25-12-21	26-12-21	27-12-21	28-12-21	29-12-21	30-12-21	31-12-21	01-01-22	02-01-22	03-01-22	04-01-22	05-01-22	06-01-22	07-01-22	08-01-22	09-01-22	10-01-22	11-01-22	12-01-22	13-01-22	14-01-22	15-01-22	16-01-22	17-01-22	18-01-22	19-01-22	20-01-22	21-01-22	22-01-22	23-01-22	24-01-22	25-01-22	26-01-22	27-01-22	28-01-22	29-01-22	30-01-22	31-01-22	01-02-22	02-02-22	03-02-22	04-02-22	05-02-22	06-02-22	07-02-22	08-02-22	09-02-22	10-02-22	11-02-22	12-02-22	13-02-22	14-02-22	15-02-22	16-02-22	17-02-22	18-02-22	19-02-22	20-02-22	21-02-22	22-02-22	23-02-22	24-02-22	25-02-22	26-02-22	27-02-22	28-02-22	29-02-22	01-03-22	02-03-22	03-03-22	04-03-22	05-03-22	06-03-22	07-03-22	08-03-22	09-03-22	10-03-22	11-03-22	12-03-22	13-03-22	14-03-22	15-03-22	16-03-22	17-03-22	18-03-22	19-03-22	20-03-22	21-03-22	22-03-22	23-03-22	24-03-22	25-03-22	26-03-22	27-03-22	28-03-22	29-03-22	30-03-22	31-03-22	01-04-22	02-04-22	03-04-22	04-04-22	05-04-22	06-04-22	07-04-22	08-04-22	09-04-22	10-04-22	11-04-22	12-04-22	13-04-22	14-04-22	15-04-22	16-04-22	17-04-22	18-04-22	19-04-22	20-04-22	21-04-22	22-04-22	23-04-22	24-04-22	25-04-22	26-04-22	27-04-22	28-04-22	29-04-22	30-04-22	01-05-22	02-05-22	03-05-22	04-05-22	05-05-22	06-05-22	07-05-22	08-05-22	09-05-22	10-05-22	11-05-22	12-05-22	13-05-22	14-05-22	15-05-22	16-05-22	17-05-22	18-05-22	19-05-22	20-05-22	21-05-22	22-05-22	23-05-22	24-05-22	25-05-22	26-05-22	27-05-22	28-05-22	29-05-22	30-05-22	31-05-22	01-06-22	02-06-22	03-06-22	04-06-22	05-06-22	06-06-22	07-06-22	08-06-22	09-06-22	10-06-22	11-06-22	12-06-22	13-06-22	14-06-22	15-06-22	16-06-22	17-06-22	18-06-22	19-06-22	20-06-22	21-06-22	22-06-22	23-06-22	24-06-22	25-06-22	26-06-22	27-06-22	28-06-22	29-06-22	30-06-22	01-07-22	02-07-22	03-07-22	04-07-22	05-07-22	06-07-22	07-07-22	08-07-22	09-07-22	10-07-22	11-07-22	12-07-22	13-07-22	14-07-22	15-07-22	16-07-22	17-07-22	18-07-22	19-07-22	20-07-22	21-07-22	22-07-22	23-07-22	24-07-22	25-07-22	26-07-22	27-07-22	28-07-22	29-07-22	30-07-22	31-07-22	01-08-22	02-08-22	03-08-22	04-08-22	05-08-22	06-08-22	07-08-22	08-08-22	09-08-22	10-08-22	11-08-22	12-08-22	13-08-22	14-08-22	15-08-22	16-08-22	17-08-22	18-08-22	19-08-22	20-08-22	21-08-22	22-08-22	23-08-22	24-08-22	25-08-22	26-08-22	27-08-22	28-08-22	29-08-22	30-08-22	31-08-22	01-09-22	02-09-22	03-09-22	04-09-22	05-09-22	06-09-22	07-09-22	08-09-22	09-09-22	10-09-22	11-09-22	12-09-22	13-09-22	14-09-22	15-09-22	16-09-22	17-09-22	18-09-22	19-09-22	20-09-22	21-09-22	22-09-22	23-09-22	24-09-22	25-09-22	26-09-22	27-09-22	28-09-22	29-09-22	30-09-22	01-10-22	02-10-22	03-10-22	04-10-22	05-10-22	06-10-22	07-10-22	08-10-22	09-10-22	10-10-22	11-10-22	12-10-22	13-10-22	14-10-22	15-10-22	16-10-22	17-10-22	18-10-22	19-10-22	20-10-22	21-10-22	22-10-22	23-10-22	24-10-22	25-10-22	26-10-22	27-10-22	28-10-22	29-10-22	30-10-22	31-10-22	01-11-22	02-11-22	03-11-22	04-11-22	05-11-22	06-11-22	07-11-22	08-11-22	09-11-22	10-11-22	11-11-22	12-11-22	13-11-22	14-11-22	15-11-22	16-11-22	17-11-22	18-11-22	19-11-22	20-11-22	21-11-22	22-11-22	23-11-22	24-11-22	25-11-22	26-11-22	27-11-22	28-11-22	29-11-22	30-11-22	01-12-22	02-12-22	03-12-22	04-12-22	05-12-22	06-12-22	07-12-22	08-12-22	09-12-22	10-12-22	11-12-22	12-12-22	13-12-22	14-12-22	15-12-22	16-12-22	17-12-22	18-12-22	19-12-22	20-12-22	21-12-22	22-12-22	23-12-22	24-12-22	25-12-22	26-12-22	27-12-22	28-12-22	29-12-22	30-12-22	31-12-22	01-01-23	02-01-23	03-01-23	04-01-23	05-01-23	06-01-23	07-01-23	08-01-23	09-01-23	10-01-23	11-01-23	12
--	--	-------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----

Attach Addi



07/12/26128
SULLIVAN
Deborah 07/12/197
Flat 0-1, 8 Boyndie Street.
Easterhouse
Glasgow, Lanarkshire
G3 8 1F

Ward:

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

[illegible]

Date: 17/1/24

1. Signed [Signature] Name Ernesto Cortez Designation CU
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent



Ward:

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

0712728128 F
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boydrie Street
Easthouse
Glasgow, Lanarkshire
G34 8JE

	Date	Word	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1	
Target >96%	
Signature:	
Print Name:	
Dr/ANP initials ONLY:	
Date:	

Sp02 Scale 2	
Target 88-92%	
Signature:	
Print Name:	
Dr/ANP Initials ONLY:	
Date:	

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response to Medical Notes	ACE Response in Medical Notes
		Think Septis If Suspected of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS¹	
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations Signed:	
Medical:	
Date:	

Date		1 hr	10 min	5 min	1 min	1 sec	1/2 sec	1/4 sec	1/8 sec	1/16 sec	1/32 sec	1/64 sec	1/128 sec	1/256 sec	1/512 sec	1/1024 sec	1/2048 sec	1/4096 sec	1/8192 sec	1/16384 sec	1/32768 sec	1/65536 sec	1/131072 sec	1/262144 sec	1/524288 sec	1/1048576 sec	1/2097152 sec	1/4194304 sec	1/8388608 sec	1/16777216 sec	1/33554432 sec	1/67108864 sec	1/134217728 sec	1/268435456 sec	1/536870912 sec	1/1073741824 sec	1/2147483648 sec	1/4294967296 sec	1/8589934592 sec	1/17179869184 sec	1/34359738368 sec	1/68719476736 sec	1/137438953472 sec	1/274877906944 sec	1/549755813888 sec	1/1099511627776 sec	1/2199023255552 sec	1/4398046511104 sec	1/8796093022208 sec	1/17592186044416 sec	1/35184372088832 sec	1/70368744177664 sec	1/140737488355328 sec	1/281474976710656 sec	1/562949953421312 sec	1/1125899906842624 sec	1/2251799813685248 sec	1/4503599627370496 sec	1/9007199254740992 sec	1/18014398509481984 sec	1/36028797018963968 sec	1/72057594037927936 sec	1/144115188075855872 sec	1/288230376151711744 sec	1/576460752303423488 sec	1/1152921504606846976 sec	1/2305843009213693952 sec	1/4611686018427387904 sec	1/9223372036854775808 sec	1/18446744073709551616 sec	1/36893488147419103232 sec	1/73786976294838206464 sec	1/147573952589676412928 sec	1/295147905179352825856 sec	1/590295810358705651712 sec	1/1180591620717411303424 sec	1/2361183241434822606848 sec	1/4722366482869645213696 sec	1/9444732965739290427392 sec	1/18889465931478580854784 sec	1/37778931862957161709568 sec	1/75557863725914323419136 sec	1/151115727451828646838272 sec	1/302231454903657293676544 sec	1/604462909807314587353088 sec	1/1208925819614629174706176 sec	1/2417851639229258349412352 sec	1/4835703278458516698824704 sec	1/9671406556917033397649408 sec	1/19342813113834066795298816 sec	1/38685626227668133590597632 sec	1/77371252455336267181195264 sec	1/154742504910672534362390528 sec	1/309485009821345068724781056 sec	1/618970019642690137449562112 sec	1/1237940039285380274899124224 sec	1/2475880078570760549798248448 sec	1/4951760157141521099596496896 sec	1/9903520314283042199192993792 sec	1/19807040628566084398385987584 sec	1/39614081257132168796771975168 sec	1/79228162514264337593543950336 sec	1/158456325028528675187087900672 sec	1/316912650057057350374175801344 sec	1/633825300114114700748351602688 sec	1/1267650600228229401496703205376 sec	1/2535301200456458802993406410752 sec	1/5070602400912917605986812821504 sec	1/10141204801825835211973625643008 sec	1/20282409603651670423947251286016 sec	1/40564819207303340847894502572032 sec	1/81129638414606681695789005144064 sec	1/162259276829213363391578010288128 sec	1/324518553658426726783156020576256 sec	1/649037107316853453566312041152512 sec	1/1298074214633706907132624082305024 sec	1/2596148429267413814265248164610048 sec	1/5192296858534827628530496329220096 sec	1/10384593717069655257060992658440192 sec	1/20769187434139310514121985316880384 sec	1/41538374868278621028243970633760768 sec	1/83076749736557242056487941267521536 sec	1/166153499473114484112975882535043072 sec	1/332306998946228968225951765070086144 sec	1/664613997892457936451903530140172288 sec	1/1329227995784915872903807060280344576 sec	1/2658455991569831745807614120560689152 sec	1/5316911983139663491615228241121378304 sec	1/10633823966279326983230456482242756608 sec	1/21267647932558653966460912964485513216 sec	1/42535295865117307932921825928971026432 sec	1/85070591730234615865843651857942052864 sec	1/170141183460469231731687303715884105728 sec	1/340282366920938463463374607431768211456 sec	1/680564733841876926926749214863536422912 sec	1/1361129467683753853853498429727072845824 sec	1/2722258935367507707706996859454145691648 sec	1/5444517870735015415413993718908291383296 sec	1/10889035741470030830827987437816582766592 sec	1/21778071482940061661655974875633165533184 sec	1/43556142965880123323311949751266
------	--	------	--------	-------	-------	-------	---------	---------	---------	----------	----------	----------	-----------	-----------	-----------	------------	------------	------------	------------	-------------	-------------	-------------	--------------	--------------	--------------	---------------	---------------	---------------	---------------	----------------	----------------	----------------	-----------------	-----------------	-----------------	------------------	------------------	------------------	------------------	-------------------	-------------------	-------------------	--------------------	--------------------	--------------------	---------------------	---------------------	---------------------	---------------------	----------------------	----------------------	----------------------	-----------------------	-----------------------	-----------------------	------------------------	------------------------	------------------------	------------------------	-------------------------	-------------------------	-------------------------	--------------------------	--------------------------	--------------------------	---------------------------	---------------------------	---------------------------	---------------------------	----------------------------	----------------------------	----------------------------	-----------------------------	-----------------------------	-----------------------------	------------------------------	------------------------------	------------------------------	------------------------------	-------------------------------	-------------------------------	-------------------------------	--------------------------------	--------------------------------	--------------------------------	---------------------------------	---------------------------------	---------------------------------	---------------------------------	----------------------------------	----------------------------------	----------------------------------	-----------------------------------	-----------------------------------	-----------------------------------	------------------------------------	------------------------------------	------------------------------------	------------------------------------	-------------------------------------	-------------------------------------	-------------------------------------	--------------------------------------	--------------------------------------	--------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	--	--	--	--	---	---	---	--	--	--	---	---	---	---	--	--	--	---	---	---	--	--	--	--	---	---	---	--	--	--	---	---	------------------------------------

Pain Score						Affix Patient ID	
Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.							
	No Pain	Mild Pain	Moderate Pain	Severe Pain	Pain Function Score		
0	1	2	3	4	A No limitations, activity unrestricted by pain or settles quickly		
			5	6	B Moderate limitations, mild activity restriction		
			7	8	C Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice		
			9	10	D Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required!		

0712726126
SULLIVAN F
-Doborn 07/12/1972
Flat 0-1, 8 Boyndie Street
-Easterhouse
Glasgow, Lanarkshire
G34 9JE

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1	
Target >96%	
Signature:	
Print Name:	
Dr/ANP Initials ONLY:	
Date:	

SpO2 Scale 2	
Target 88-92%	
Signature:	
Print Name:	
Dr/ANP initials ONLY:	
Date:	

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observations	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Septals IF Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS	
Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations	
Signed: _____	
Medical: _____	
Date: _____	

[illegible]

Deborah S. Mirman

[illegible][illegible][illegible][illegible][illegible]

Blood Pressure mmHg

(Score uses systolic BP only)

120 115
90 85
70 65
50 45
30 25
10 0

220 215 210 205 200 195 190 185 180 175 170 165 160 155 150 145 140 135 130 125 120 115 110 105 100 95 90 85 80 75 70 65 60 55 50

2117	3
121-126	2
111-128	2
101-118	1
91-108	1
81-90	0
71-80	0
61-70	0
51-60	0
41-50	1
31-40	3
21-30	3

[illegible][illegible][illegible][illegible]

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE	
A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

07/27/26128
SULLIVAN
Deborah
Flat D-1, 8 Boyndie Street
Eastonmoss
Glasgow, Lanarkshire
07/12/1972
F
G34 RUE

Abbreviations for recording oxygen device	
A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Venturi Mask and % eg. V24
NIIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HPN	High Flow Nasal Oxygen
NEB	Nebuliser
AM	Reservoir Mask (Emergency use only)

07/22/2012
SULLIVAN
Dubovich
Flat D-1, 8 Boydell Street
Eastonhouse
Glasgow, Lenavashire
F
07/21/1972
G34 81E

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 2/7/23 Time: 0820

0712726128
F SULLIVAN F
2 Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE



Assessment Complete by: Name NURSE (Please Print)

Julie Shore

Patient Prep / Investigations

(Please tick/circle when completed)

Prepare patient for examination / Clothing bag labelled + stored



GGC RED BAG - with patient



12 Lead ECG



Weight:



Blood Samples Obtained: Yes ☒ No ☐

IV Access: Yes ☒ No ☐

Blood Gas: VBG ☒ ABG ☐

Communication

(Please Circle Tick)

NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)



ID Band



Peak Flow



Xrays / CT Scan Performed:



Relatives / NOK informed (Carers)



Child Protection Concern (considered in line with policy)

Y/N

Adult Support and Protection

Y/N

Urinalysis

Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	++++ ☒	PH		S.G.	
MSSU / CSU	☐	Toxicology	☐				
HCG	☒	+VE	☐	-VE	☒	Strip No -	

Screening Tools

(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more

Y/N

SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)

YES

Mental Health Triage Assessment

Y/N

If NOT WHY? - (details)

5/12

NO

GMAWS

Y/N

Date - 2/7/23

Time - 0825

Signature -

[Signature]

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)

> = 7 correct	0
< 7 correct	1
Unstable	2

Mental status according to family/carer

Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

Alertness

Normal	0
Mild sleepiness	0
Clearly abnormal	4

4AT score

/12

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

YES NO

F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

YES NO

Clear need for other specialty input eg exacerbation of known long term condition such as COPD	}	
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- **Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.**

If **NO** to the list in step 2:

- **Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.**

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	5) Skin	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	6) Judgment	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

[illegible]

0712726128
F SULLIVAN
2 Deborah Add: Oct 07/12/1972

At risk of falls?

(clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) At risk complete risk assessment

YES

NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGG RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	Please note here if any other tasks required prior to transfer
Belongings (including patients medication)		☐	Always	
SAS Transport required and ref. no.		☐	☐	
Print Name				
Sign -				

Nursing Notes		
Date and Time		Print Name and Signature
21/11/23	SUSA 40 abdo pain onset 0300.	
0825	Given 10mg IV morphine with	
	SATS. TIF to bay 17 +	
	bloods obtained. Cocodamol	
	30/500mg x2 given.	
1000	Further analgesia / anti emetic given	

[illegible]

My Admission Record



Hospital: GR1 Ward: 66
 Date of Admission: 02/12/23 Time: 1255
 Information obtained from: Name: Debbie
 Patient ☒ Relative ☐ Other ☐
Preferred Name: _____
 Age: 50 Telephone Number: 07713718392
 Consultant: MARSHALL

Nat: _____
 Adr: 0712726128
SULLIVAN
Deborah F
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
 CH: _____
 Affix patient ID: G34 9JE

urine ☒ - NAD

Communication	
What is your first language? <u>English</u>	
Do you require an interpreter?	Yes ☐ No ☒
If yes, provide details of arrangements made _____	
Do you use British Sign Language (BSL)?	Yes ☐ No ☒
Do you need someone to help you to communicate?	Yes ☐ No ☒ If yes, who _____

Preferred first contact	Preferred second contact
Name: <u>Donna Sullivan</u>	Name: <u>not offered</u>
Relationship: <u>sister</u>	Relationship: _____
Address: _____	Address: _____
Telephone: <u>07743956178</u>	Telephone: _____
Is this person aware of your admission?	Is this person aware of your admission?
Yes ☒ No ☐	Yes ☐ No ☐
Can we share information with this person?	Can we share information with this person?
Yes ☒ No ☐	Yes ☐ No ☐

Presenting Complaint / Diagnosis

epigastric pain

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ Doloxetene, opiates, codiene
PENICILLIN

Relevant past medical history

Delayed gastric emptying Fibromyalgia PTSD
Prev lap chole HTN
Prev fundoplication x2 Pancreatic Diabetes
Prev appendectomy Chronic Pancreatitis

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
 Yes ☐ No ☒ If yes, Who asked for a copy? _____

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☒**OR**

Does someone have Guardianship?

Yes ☐ No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☒

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47**Carbapenemase-producing enterobacteriaceae (CPE)**

Have you ever:

1. Been an inpatient in a hospital outside Scotland?
2. Received holiday dialysis outside Scotland?
3. Been told that you have CPE?
4. Been in close contact with a person with CPE?

Yes No

☐ ☒
☐ ☒
☐ ☒
☐ ☒If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'
and inform the IPCT☒
☒
☒
☒**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

Yes No Unsure
☐ ☒ ☐If **YES** complete the following section

1. Have you ever been told that you have MRSA?
2. Have you been admitted from another hospital/ residential setting or care home?
3. Do you have a wound / skin ulcer or invasive device which you had before admission?

☐ ☒ ☐
☐ ☒ ☐
☐ ☐ ☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

Yes No Unsure
☐ ☒ ☐If **YES** inform the IPCT ☐

Name: 
 Add: 0712726128
 SULLIVAN
 Deborah
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 Glasgow, Lanarkshire
 CH
 Affix patient ID label
 07/12/1972
 F
 G34 9JE

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☒ when did you stop? 5 years ago

Never smoked ☐

Do you use eCigarettes? Yes ☒ No ☐

If a smoker, the NHS GGC-Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☒

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☒

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHS GGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): LLOJSEN

Signature: LLOJSEN

Designation: SIN

Date: 02/17/23

My Assessment Record

Name: _____
 Address: 
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 DoL: _____
 CH: Glasgow, Lanarkshire
 Affili: _____ G34 9JE

1. Breathing and Circulation

Breathing	Admission Presentation	Normal for the patient	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation	Normal for the patient	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes	No	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?	✓	✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team?		✓	
Contact details:			

Na	
Ad	0712726128
	SULLIVAN
	Deborah
	07/12/1972
Do	
CP	
Aff	

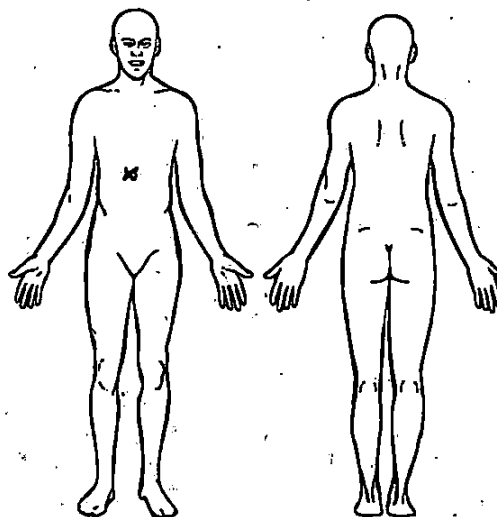
3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☐ Reading ☒ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?		✓	
Do you wear a prosthesis?		✓	
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Name: _____
 Address: _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix pi: G34 8JE

4. Cognitive Status	THINK DELIRIUM		Assessment of the patient's cognitive status
	Admission Presentation	Normal for the patient	
Alert and orientated	✓	✓	
Impaired conscious level	✓		
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NIA

What do you like to eat and drink?

not fussy

What do you not like to eat and drink?

not fussy

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation	Normal for the patient	Name:  Address: 0712726123 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire CHI: G34 9JE Affix:
Normal diet and fluids	✓	✓	Assessment of the patient's hydration and nutrition needs on creon for chronic pancreatitis
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name: A:  0712726128 SULLIVAN Deborah 07/12/1972 Do: Ch: Aff:
Haematuria			
Incontinent			

N.B. If new Incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

0117

How often in a day/week do you have a bowel movement? Per day ☒ x 1 Per week ☐

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

N: _____
 Ac:  _____
 0712726128
 — SULLIVAN _____
 — Deborah _____
 — Flat 0-1, 8 Boyndie Street _____
 D — Easterhouse _____
 C — Glasgow, Lanarkshire _____
 A: _____ G34 9JE

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation	Normal for the patient	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation	Normal for the patient	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer	✓	✓	
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes	No	Description of any dental work
Do you wear dentures?	✓	✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			
Skin Care	Admission Presentation	Normal for the patient	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____

Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name _____ Address _____ 0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse CHI: Glasgow, Lanarkshire Affix _____ 07/12/1972 G34 9JE
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

Name: _____
 Ad: _____
 0712726128
 SULLIVAN
 Deborah
 DoB: Flat 0-1, 8 Boyndie Street
 CHI: Easterhouse
 Affix: Glasgow, Lanarkshire
 07/12/1972
 G34 9JE

11. Social Circumstances		
Do you:		
Live alone ☒	Live with family/ friend/ other ☐	
Live in a nursing home ☐	Live in a care home ☐	
Live in residential supported care ☐	Live in student accommodation ☐	
Live in 'homeless' accommodation ☐	Have no fixed abode ☐	
Other please specify _____ ☐		
Dependants	Yes ✓	No ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?	✓	
Do they need support from someone else whilst you are in hospital?	✓	
Would someone else be able to provide this support when you are in hospital? If yes, who? <u>daughter</u>	✓	
If no support available contact Duty Social Worker		
Duty Social Worker Required ☐ Not required ☐ Referred ☐		
Services	Yes ✓	No ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		
12. Emotional and Spiritual Care		
Do you have a religion or beliefs that we can help you observe while you are in hospital? <u>NA</u>		
Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?		
Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☐		
Healthcare Chaplain informed. Yes ☐ N/A ☐		

Name:

Adi



0712726128

SULLIVAN

Deborah

07/12/1972

Dol

Flat 0-1, 8 Boyndie Street

CH

Easterhouse

Glasgow, Lanarkshire

Affi

G34 9JE

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

get home

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

*family
daughter*

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐

Name: _____
 Address: 
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 DoB: Flat 0-1, 8 Boyndie Street
 CHI: Easterhouse
 Glasgow, Lanarkshire
 Affix: G34 9JE

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☒

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☒

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☒

Self-employed ☐

Retired ☐

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☒ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☒

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐

Not appropriate to ask at this time ☒

If yes when was patient referred ____/____/____

Name: _____
 Address: _____
 0712726128
 SULLIVAN F
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 DoB: Easterhouse
 CHI: Glasgow, Lanarkshire
 Affix p G34 9JE

Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me - Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (FUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
02/12/23 1320	Admitted to ward 66 from ED with epigastric pain - ? flare chronic pancreatitis. News @ on admission BM 6.0. IVF in progress. Admitted for fluids, antiemetic, analgesia. Morphine given iv in ED - comfortable.	

Name: _____
 Adc:  _____
 0712726128
 SULLIVAN F: _____
 Deborah 07/12/1972
 Flat 0-1, 8 Boyndie Street
 Do: Easterhouse
 CHI, Glasgow, Lanarkshire
 Affi: _____ G34 9JE

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	@ time of admission. ED	
	Doctor documented opiate	
	allergy - Patient denies	
02/12/23	this. Await surgical review. -	L. SULLIVAN (SN)
1500	Urinalysis -ve -	L. SULLIVAN (SN)
1730	Mobile and independent	
	with all ADL's. Passing urine	
	spontaneously. Bowels	
	inactive. Normal diet and	
	fluids when able, sips	
	only at present. Medications	
	given as per Hepma. News	
	Score = 0. Has slept most	
	of this afternoon. -	L. SULLIVAN (SN)
1930	WR - AXR + CXR ☐	
	- sips only ☐	
	- bloods in AM ☐	
	- ECG ☐	L. SULLIVAN (SN)
3/8/23	Attended A+CXR - Await	
N/S	results. News 0.	
	Independent.	
	Passing urine freely.	
	IVF ongoing. Meds + Analgesia	
	as hepma. Anti-emetics	
	given. Appears settled	Smookey & W
10:30	WR - for laxatives	
	AXR / CXR (N)	He (SN)

Affix patient ID label

G34 9J

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
03/07/23	D/S	
13:15	All care needs met as planned. Eating and drinking. Independently mobilising. Passing urine. Obs taken and stable. Meds given as per Hepma	SN R-Leonard SN
	Wk Reg Patient U bowel active. Fit for discharge	SN R. Patel SN
18:00	Patient discharged home Vaseline taken out - bloodstain advice given. Dose box returned to patient from medication tray	SN R-Leonard SN SN

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or

0712726128

Name: SULLIVAN

Deborah

DOB: Flat 0-1, 8 Boyndie Street

Ward: Easterhouse

Glasgow, Lanarkshire

13 F

07/12/1972

Hospital:



G34 9JE

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☒

Fluids ☒

Transfusion ☐

PVC inserted: Day 0

Date: / /

Hospital:

Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ Unknown ☐

Insertion site:

R Hand ☐

R Arm ☐

R Foot ☐

L Hand ☐

L Arm ☒

L Foot ☐

Other:

Colour of cannula:

Blue ☐

Pink ☒

Green ☐

White ☐

Grey ☐

Orange ☐

Explanation and PVC
leaflet provided to
patient/ carer

Yes ☐ No ☐

If No, state reason: inserted in ED

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria?	VIP score. (See Chart on back of care plan)	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 03/07/23	Yes ☒ No ☐ If No, remove PVC and record date and reason*.	VIP: 0 If ≥ 2 remove PVC and record reason*.	Yes ☒ No ☐	Yes ☐ No ☐ N/A ☒	R-L
Day 1 Check 2 Night	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: / / Reason for keeping PVC in after 72 hrs/ 3 days:

*Date PVC Removed: / /

*Reason For Removal:

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:

Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Date: 3/7/23

1. Signed [Signature] Name SHOENEL Designation SN
2. Signed [Signature] Name KIRSTY FRASER Designation SN
3. Signed _____ Name _____ Designation _____

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

07/12/2018
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
07/12/197

Ward: 65

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

NHS
Greater Glasgow
and Clyde

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label	
----------------------------	--

Ward:



Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Date: 02/7/23

Attach Ar



07/12/1972

NHS
Greater Glasgow
and Clyde

Ward:

66

USE FOLLOWING CODES:

Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label



Ward:

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

[illegible]

Pressure Ulcer Daily Risk Assessment (PUDRA)

 0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: EGR1 Ward: 66	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
---	--	--

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
01/12/23	12:40	N	N	N	N	N	N	4 hrly	W Russell
3/12/23	13:35	N	N	N	N	N	N	4 hrly	KF
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan



Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Attach Addressograph

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree plan with patient / family/ carer: YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____



0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire

G34 9JE

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 66 Date: 02/11/23 Time: 12.40	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	NA				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHS GGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	✓				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

ALL patients in older people's wards must have an interventional plan in place (overleaf)

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			✓								
2. Does the patient have cognitive impairment or a possible delirium?			✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?			✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?			✓								
5. Based on your clinical judgement, is this patient at high risk of falling?			✓								
Signature of nurse completing assessment / update		L. Russell									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time:	Time:	Time:	Time:	Time:

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.

(Patient care plan 8)

Assess if a low bed is required

(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.

(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.

(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT – follow THINK DELIRIUM guidelines.

(Patient care plan 4)

Document continence problems and link to care rounding

(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.

(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.

(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.

(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.

(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.

(If appropriate)

Signature of nurse completing Interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN



SULLIVAN

Deborah

Elect 0:4 8 B.

Flat 0-1, 6 Boyndale Street
Eastbourne

Easternhouse

Glasgow, Lanarkshire

patient) Moving and Handling Assessment Form

[illegible]

Continuation Sheet

1. General information (Only complete this section if changed from over page)									
Body Build			Problems with comprehension, behaviour, co-operation (specify):						
Weight		Height		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):					
Kg		cm							
BMI									
Risk of Falls: Yes ☐ No ☐									
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
Model		Aid Type	People: 1	2	>3	Additional Information / Equipment:			
Sling type									
Sling Size									
3. Toileting									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	>3	Additional Information:			
4. Move on / off bed pan									
Hoist	Manoeuvre		Assistance			Supervision		N/A	
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	>3	Additional Information:			
		Monkey pole							
		Person bridges							
5. Move up / down bed									
Hoist	Handling Aids		Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	>3	Additional Information:			
		Monkey pole							
		Rope ladder							
6. Lateral Transfer to / from trolley / bed									
Hoist	Handling Aids		Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	>3	Additional Information / Equipment (eg sliding sheets):			
		Other (Please specify)							
7. Sit up over side of bed									
		Bed Rest	Assistance			Supervision		Independent	
			People: 1	2	>3	Additional Information / Equipment (eg rope ladder, swivel cushion):			
8. Into Bath or Shower									
Equipment	Handling Aid		Assistance			Supervision		Independent	
Shower	Shower chair		People: 1	2	>3	Additional Information / Equipment (eg sling lifting hoist after risk assess):			
Variable / Fixed height bath	Shower trolley								
Bed bath	Bathing hoist (eg Alenti)								
9. Walking									
No Walking	Walking Aid		Assistance			Supervision		Independent	
		see 'sit to stand transfers'	People: 1	2	>3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)			
10. Other Instructions / Observations / Equipment Used									
			4th Assessment		5th Assessment		6th Assessment		
Recording Symbol:			/ Forward slash		X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists add slashes to make a star		
Date Assessed:									
Assessor's signature:									
Proposed Review date:									

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS
Greater Glasgow
and Clyde

Date <u>02/12</u> Time <u>12</u> of initial height and weight on admission to hospital <u>5ft 9</u>	Actual	* Patient reported	* If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height <u>175</u> cm	☒	☐	
Admission Weight <u>88.9</u> Kg	☒	☐	

* Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	<u>02/12</u>						
Time	<u>1305</u>						
Ward	<u>bb</u>						
Oedema/ Ascites present Y/N	<u>N</u>						
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	<u>/</u>						
Weight (kgs)	<u>88.9</u>						
BMI	<u>29</u>						

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	<u>0</u>						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	<u>0</u>						
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	<u>0</u>						
Step 4 Overall Risk of Malnutrition TOTAL	<u>0</u>						
Rescreen on							
Signature	<u>L2</u>						

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patient's Intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with Ⓢ
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

Complete the above steps

NO

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
 - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
 - Offer full cream milk with and between meals.
 - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a 72 hour period?

YES

Is the patients Intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Complete the above steps

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

DISCHARGE

IF the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

[illegible]

